In This Issue:

Research in Rehabilitation of the Mentally Ill

June, 1961 Volume XXII, No. 6

REHABILITATION LITERATURE

National Society for

Crippled Children and Adults

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REHABILITATION LITERATURE

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June, 1961, Volume 22, No. 6

Published Monthly by
National Society for Crippled Children and Adults, Inc.
2023 West Ogden Avenue, Chicago 12, Illinois
Dean W. Roberts, M.D., Executive Director
Second class postage paid at Chicago, Illinois.
Subscription rates: $4.50 a year, United States; $5.00 a year, other countries. Single copy: 50¢, United States; 60¢, other countries.

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REHABILITATION LITERATURE

Article of the Month

Research in Rehabilitation Of the Mentally Ill

George W. Brooks, M.D.

William N. Deane, Ph.D.

About the Authors . . .

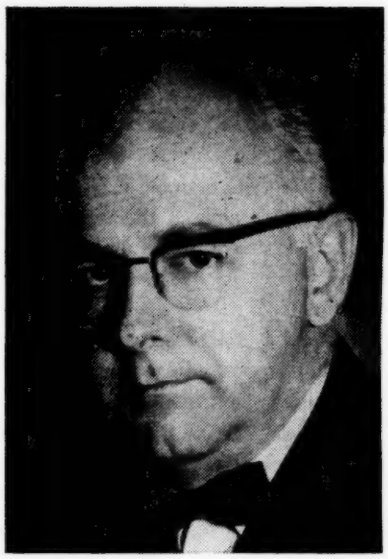
Dr. Brooks has been assistant professor of psychiatry, University of Vermont College of Medicine, Burlington, and the director of research and staff education, Vermont State Hospital, Waterbury, since 1957. He earned his M.D. degree at the University of Vermont in 1944 and was certified by the Board of Psychiatry and Neurology in 1955. Dr. Brooks belongs to the American Psychiatric Association and the National Rehabilitation Association. He has been a frequent contributor to the literature with articles dealing with psychiatric conditions, the use of drugs therein, and rehabilitation.

Dr. Deane has been research associate, department of psychiatry, University of Vermont College of Medicine, since 1957 and sociologist with the Vermont State Hospital since 1960. He served as sociologist on the Vermont Project for the Rehabilitation of Chronic Schizophrenic Patients (OVR SP-180) from 1957 to 1960. Dr. Deane received his Ph.D. degree in 1954 from Washington University, St. Louis, Mo., and is a member of the American Sociological Society. Dr. Deane has been both a clergyman and a college professor.

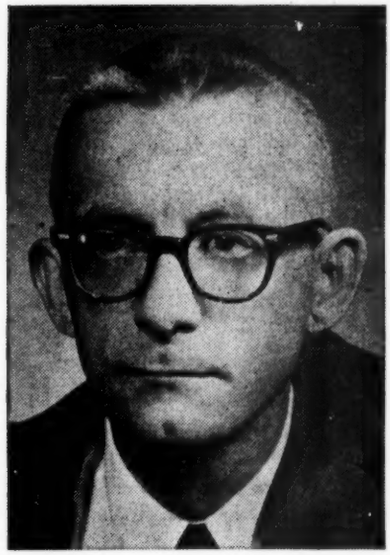
This original article was written especially for Rehabilitation Literature.

AS A WORD, rehabilitation sometimes seems to mean all things to all people. Because we have become concerned about the disabling effects of long-term hospitalization[24] of mental patients and the relief or amelioration of these effects by social therapies, rehabilitation has become identified with social psychiatry, or the attempt to relate integrally the social and cultural dimensions exemplified by groups to the psychodynamics of the individual. Because active rehabilitation research and demonstration usually implies the workings of multidisciplinary teams, rehabilitation has sometimes been confused with all multidisciplinary research and demonstration in the treatment of mental illness. Similar identification has been made conceptually with the "therapeutic community," "community psychiatry," "public health psychiatry," and many other modern trends in psychiatric hospital care and treatment. Also, so much of the work in this field is concerned with the chronic schizophrenic patient that sometimes this segment of the problem is taken for the whole.

For purposes of this review, we will attempt to return to a more delimited definition of rehabilitation such as that of Rusk,[42] "to assist the patient in reaching the maximum of his physical, emotional, social, and vocational potentials." This is "in contrast to 'convalescence,' in which the patient is left alone to rest through the period while time and nature take their course." Rusk also points out that the very success of modern hospital practice is rapidly increasing the problem of the disabled and that we are witnessing a change in our philosophy about these matters to the point where we increasingly feel that our responsibility ends only when the individual is retrained to live and work with what is left. The concept and practice of rehabilitation, of course, may be very important much earlier in the course of the disease, as the availability of rehabilitation efforts provides a more hopeful atmosphere permitting more specific therapeutic measures to be applied. However,



Dr. Brooks



Dr. Deane

rehabilitation as viewed here is concerned with all the various modalities of care that assist the patient to make the most of his life after the termination of active disease.

A number of excellent reviews and collections of articles concerning the rehabilitation of the mentally ill have been published recently.[1, 10, 20, 27] In *Rehabilitation of the Mentally Ill,* Williams[46] clearly pointed out that the focus of our attention in this field is on how can we "help the patient to achieve optimal social role (in the family, on the job and in the community generally), within whatever capacities and potentialities he may have? How can [we] help to reduce the prevalence of disabilities, especially social disabilities resulting from mental and emotional disorders?"

Another very thorough review of the general field of the rehabilitation of psychiatric patients has been published by Kissin and Carmichael,[29] which is accompanied by a very adequate bibliography. They suggest that "the idea of social and economic productivity in former patients arose only with a change in the basic philosophy regarding mental illness itself and with the change from custodial to therapeutic considerations. In this area are the most resisted concepts. From the concept that a person had to be taken care of—through the idea of one who had to be helped to take care of oneself—to that of a person who could take care of himself but might need some assistance in regard to particular difficulties has been slow and a by no means universally accepted change."

Few of these recent writers have concerned themselves specifically with advances in technics of working with the mentally ill. They have been more concerned with the expanding use of already well-established methods of social therapy, remotivation, re-education, and retraining.

Perhaps the more significant advances in the field have been those attempts to make searching analyses of problems of research and evaluation. Outstanding among these is the volume by Meyer and Borgatta[37] in which they conclude, "There is no substitute for the labor of painstaking research and no escape from the commitments it demands." Several others have become concerned with these areas. Landy[32] concludes that research must be rigorously designed, utilizing control groups whenever possible, and should follow the traditional methodological procedures and canons of demonstration. In this view, research and therapy are rigorously separated. James[26] essentially adopts a similar attitude. On the other hand, Deane[9] argues for the view that frequently therapy and research are inseparable and that both must often be conducted simultaneously and with the same personnel with the affective state of the research-therapist constituting a major factor in the results. Meszaros[35] feels that research methods must be adapted to the treatment program and that both are integral to the fullest realization of the therapeutic setting necessary to successful rehabilitation.

Essentially, two points of view seem to be emerging. The first, reflected by Landy[32] and James[26] among others, emphasizes the more classic research design that separates research from therapy; the second, enunciated by others, including Deane[9] and Meszaros,[35] places emphasis on the inter-relationship between research and therapy and tends toward concern with the more introspective and less quantitative type of data. The Group for the Advancement of Psychiatry[22] has in one of its monographs explored rather extensively these emergent views.

A major step forward in problems of research and evaluation does not appear directly in the literature but was taken through a large conference on Problems in Research and Demonstration Projects in Rehabilitation and Management of Mental Disorders held at the New York Psychiatric Institute in June, 1959, and sponsored by the National Institute of Mental Health. Here about 50 working papers were presented by teams of researchers from leading research centers throughout the nation. The con-

ference performed an invaluable service in bringing people from most of the centers of research in rehabilitation of the mentally ill together for an extended exchange of views. Unfortunately, none of the proceedings are readily available in printed form at this time. However, much discussion, many individual papers, and subsequent research were undoubtedly stimulated by this experience.

Among other attempts at integrating the approaches to research in treatment and rehabilitation of the mentally ill, mention should be made of a comprehensive volume, edited by Kruse,[31] which records the results of two very extensive conferences sponsored by and held at the New York Academy of Medicine in 1957. Here representatives from several social, psychiatric, and biological sciences attempted to define more precisely areas of acceptance and nonacceptance among their several fields on problems relating to the understanding of mental illness as well as the problems and modes of procedure relating to effective uses of a multidisciplinary approach. A similar striving toward a unified theory from which research and therapy could proceed was undertaken by Grinker[21] in 1956. The specific conclusions at which these volumes arrive are too numerous and complex to be discussed in the present text.

Other very interesting and provocative attempts at unification of the rehabilitation field are detailed in articles by Williams[47] and Levinson.[34] Williams[47] attempts to relate more general theoretical social models, particularly that of Parsons, to specific research questions. The importance of his paper may lie in his conviction that "global" theoretical systems may have demonstrable meaning in concrete social settings and in his view that some existing social theory may constitute a sound basis for research and demonstration, thereby linking more general knowledge to the specific area of rehabilitation. Naturally, such an approach would make the rehabilitation field less virgin from a theoretical point of view.

Levinson[34] calls attention to the lack of unity in mental hospital research generally by noting the variation of sample size in many studies reported, the laxity of precision in measuring or delimiting variables, and the differing research and theoretical orientation of many workers. He also analyzes the role dilemmas of the investigator in the mental hospital, where he must constantly attempt to resolve situations of conflict in which there are not only great opportunities for research but also great limitations imposed by realities that may conflict with the necessities involved in the investigation and thereby threaten compromise at crucial points. He feels that proper consideration of these dilemmas may help resolve them and may lead to a greater awareness of real problems on the part of future investigators, which may in turn produce a series of investigation principles that may help clarify and unify the field. He also calls attention to the research directions he considers to be essential at the present time. These may be broadly summed up as relating to the needs of the patients, determining the efficacy and therapeutic effectiveness of staff roles, hospital value systems, and social structure. With Williams, he suggests that adequate study of the mental hospital and its patients may relate to existing social theory or lead to a general theory of "welfare type" organizations.

From a methodological point of view, Freeman and Simmons[15] have published a general discussion of the use of the survey method of investigation in research in which they indicate, among many findings, that they found it necessary to use social workers already familiar with and sophisticated in the problems of mental illness and that reliable survey data could be obtained only by the use of such personnel. Two of the more recent discussions of problems resulting from the indispensable interdisciplinary nature of research and rehabilitation of the mentally ill are contained in publications, one by Simmons and Davis,[44] which emphasizes the need for long-term development of understanding among the various members of the team, and one by Redlich and Brody,[40] which stresses the complex nature of the blending of defenses against inner conflict, which research activity represents for various members of the team.

More problems relating to the evaluation of results of demonstration projects have been extensively dealt with by Meyer and Borgatta, as noted above[37] and also in a separate publication,[36] which emphasizes, among other things, the necessity for a precise description of the process of patient selection as well as the need for clear-cut criteria by which to measure success in rehabilitation.

The rapid expanse in the application of old technics may in part be due to a new, more vigorous and sophisticated concern with the problems of interdisciplinary and interagency co-operation. Key's[28] work is an example of these. Using an operational approach he investigates the problems of co-ordinating and appraising the effectiveness of the many emerging ancillary therapies within the mental hospital and concludes that the directing and co-ordinating of the various disciplines "will be the task of a coordinator skilled in management techniques cognizant of the importance of matching the skill and personality of the therapist to the needs of the patient, and trained to understand the social structure of the hospital in order to coordinate the activities of the department with the rest of the hospital."

In addition to the specific problems of co-ordination of interdisciplinary research, Scher[43] has called attention to the lack of structure in the social dimensions of psychotherapeutic work. He states the lack of structure supports the all too present anomic tendencies of the situation for the patient and that the resolution of the

illness is strongly dependent on the inherent degree of order provided in the setting. Of course the classic example of a study of this sort is provided by Stanton and Schwartz[45] in their analysis of Chestnut Lodge in which they call attention to negative reactions by patients to unexpressed staff hostilities when those harboring the hostilities work with the same patients.

A more complex approach to the significance of small group dynamics in the development of mental disorder is presented in a series of articles by a group at Palo Alto. This work is exemplified by Bateson,[5] who concludes in one of his writings that "the schizophrenic family is an organization with great ongoing stability whose dynamics and inner workings are such that each member is continually undergoing the experience of negation of self." It is hoped that small group dynamics, as measured and analyzed by Bales,[4] for example, may eventually coordinate with Bateson's work in showing the nature of the schizophrenic interactional pattern during later stages of the disease process.

The proper role of the psychiatrist as a "social system clinician" is outlined by Greenblatt.[19] He states:

Administrative leaders must often hold to an equalitarian philosophy (against pressures from threatened personnel) as regards the potential of *various* categories of personnel to assert a wholesome influence on patients. They have the task of de-emphasizing roles and status insofar as the structuring of roles tends to promote inflexibility and preclude or limit relationships that could be of benefit to patients. Often this implies a specific attack upon the self-image of the profession with its rigid prescription of tasks and functions; for it must be recognized that the patient's illness knows no professional boundaries. No role group can be permitted to exist in an "inferior" position in the hospital organization. Exchange of information between, and mutual instruction of, various service groups is basic to greater understanding and acceptance of the worth of each worker in the hospital community.

Among other significant advances in technics in the field of mental patient rehabilitation are those studies that have attempted an evaluation of community attitudes and resources. These attempts have been brought into sharp focus because of concern in rehabilitation efforts with problems of former patients' reinstatement in acceptable vocational and social settings. Among some of the outstanding studies published in this area are those by Olshansky[39] in which he found some difference between the stated employment attitudes of employers toward hiring former mental patients and their actual performance in providing employment for them. Similar findings have been reported by Crawford and others from the Hogg Foundation. One study by Crawford, Rollins, and Sutherland[8] was compared with a previous study by Jaco[25] in which he also concluded that a disparity often exists between what people say and what they do. They found there had been an improvement in the community attitude during the years after Jaco's study but that it still had apparently not markedly affected easing of the former mental patient's problem of transition.

In another study,[41] of aging persons returning to the community from a state hospital, the same authors found a basic social conflict in that, although dependency needs of this group in physical, social, and financial areas were at their highest point, they tended to live in units of three or fewer people and were expected to be quite independent if they were to remain in the community. A study in this same area by Landy and Griffith[33] of 52 employers found that a high proportion of community employers were receptive to the idea of employing the emotionally handicapped and that later a large proportion of the group actually did accept placements referred directly by a psychiatric hospital.

Two reports of adverse community reaction to a project have been made by Eldred[11] and Brooks[6] in separate publications. Brooks concluded that "a controversial issue which attracts the attention of many people of good will is effective in arousing warm community support for" a rehabilitation house. On the other hand examples of more favorable community acceptance are cited by Gralnick,[18] Kris,[30] and Brooks.[7] Gralnick found it necessary to have not only an integrated social structure within the therapeutic community that will insure active patient participation but also a total treatment concept that will insure active participation of the family and the private psychiatrist. In the discussion of Gralnick's paper, Fink pointed out how essential it is to define the population that any such total rehabilitation program serves, as the relationships involved may be quite different for a private hospital or the back wards of a state hospital, for example. Kris[30] exemplified this point by discussing the application of the therapeutic concept to an aftercare clinic for a quite different class of patients from that served by Gralnick's hospital.

Perhaps the most intensive and extensive study of community relationships to problems of mental disorder and rehabilitation in this field are the monumental volumes of Hollingshead and Redlich[23] and Myers and Roberts,[38] who clearly outline the evidence that community attitudes of all types are powerful determinants in selection of patients for rehabilitation, the methods used, and the success of the effort.

The most detailed studies of the posthospital acceptance of former mental patients perhaps have been undertaken by Freeman, Simmons, and others[13, 14, 16, 17] in their group at Harvard. They[17] found in an urban setting that families of former mental patients frequently expressed dissatisfaction with living arrangements. They were unable to establish clearly that desire to move is related to avoiding the stigma of mental illness. However, the possibility of such stigma's being associated with the urban residential mobility rate of former patients' families

could not be totally ruled out. In another study the authors[16] conclude that a negative correlation occurs between possessiveness of mothers of schizophrenic patients and the amount of their education. A similarly negative correlation occurs when possessiveness is correlated with income and rent.

Another article by Freeman and Simmons[14] has established a relationship between the relative social class and the tolerance of deviance, finding that there was a higher tolerance in the lower class groups. They also made the interesting suggestion:

The findings of Hollingshead and Redlich that lower class psychotic patients are under treatment for more years than higher class patients may, to some extent at least, be a function of the development of graver illness before their more tolerant families sought treatment for them.

Freeman and Kassebaum,[13] in a carefully designed study of the relation of education and knowledge to opinions about mental illness, found, interestingly enough, that there was little significant difference that could be related to the level of formal education or knowledge of the technical vocabulary of psychiatry. They suggest that "practitioners associated with mental hygiene and health education programs . . . be cautious in thinking that giving the people the facts alters their opinions." All the Harvard studies agree strongly with the "proposition that the differential tolerance of family members is critical to the posthospital fate of the mental patient."

Another rather detailed study of the family as a resource in the rehabilitation of the mental patient is that reported by Evans and Bullard[12] in which they observed a fairly high incidence of continued support and interest even among families of long-term patients but at the same time noted that the effectiveness of their interest was limited by such factors as a paucity of available family members, economic insecurity, insufficient living space, and general familial ineptness in giving assistance in finding work or in providing social resources. A community study by Baker, Thorpe, and Jenkins,[3] partially replicated by Evans and Bullard,[12] clearly delineates the area for needed rehabilitation facilities by finding that about one fourth of their long-term group of patients in Netherne Hospital in England could have a trial outside the hospital if homes, hospitals, or rehabilitation houses were available for their support, since in no case in the study was an adequate home available for any of these residually disabled individuals.

A few researchers have explored new and exciting fields of endeavor,[2, 48] somewhat related to the above but more concerned with structuring the social situation so as to permit a "working through" of pathological material in ways that can ultimately be related to normal social living. Wittkower and Azima[48] make a strong plea for the view that "the practical value of occupational therapy could be enhanced if it could be made meaningful in terms of psychodynamic concepts." They also summarized a tentative reconceptualization of occupational therapy under the headings of "sublimation," "projection," and "gratification." They have continued efforts to refine and expand this work as recently summarized by Azima[2] in a paper at the Eastern Psychiatric Research Association meeting in New York City in November, 1960, which will be published.

In summary, the present writers would suggest that although specific technics for working with the former mental patient to maximize his social and vocational potential have not been significantly refined in recent years, technics of research, interdisciplinary co-operation, and analysis of community acceptance have begun to yield exciting advances so that we can foresee the day when the continuation of such activities will not depend on the accidental optimism of particular leaders in the field but will be more solidly based in a body of scientific knowledge. This should help to reduce the shameful undulation between progression and regression, which has been characteristic of this field in the past.

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Review of the Month

Welfare in America

by

Vaughn Davis Bornet, Ph.D.

Published by University of Oklahoma Press, Norman, Okla. 1960. 319 p. illus., tabs. $4.95.

Reviewed by Leonard W. Mayo

THIS BOOK SHOULD BE WIDELY READ by social workers and by laymen interested in the welfare field. It is primarily an appraisal of the social welfare movement in the United States, with special emphasis on some of the major aspects of the social work program, including fund-raising methods; the profession of social work and social workers themselves do not escape analysis.

Mr. Bornet writes well and on the whole reveals a good grasp of many aspects of the social welfare movement in the United States. He has a sense of history, which lends some depth and perspective to his observations. The publication of this book was aided by a Ford Foundation grant.

For the most part the analyses by the author are objective and he neither plays up nor plays down the strengths and weaknesses of social welfare as he sees it. Social workers will not be entirely happy with his appraisal of them and their profession. Perhaps this is to be expected in a report of this kind, for few professional people find themselves in full agreement with the evaluations of them and their work written by others.

The author knows that the Lady Bountiful of the early 1900's no longer exists in this country, but it is not clear that he is fully cognizant of the sweeping changes that have taken place in social work philosophy and practice—from "charity" in the narrow sense to the humanitarian-scientific approach in the broad sense. No social worker worthy of the name was ever without warmth and understanding; the difference between the social worker of yesterday and today lies, not so much in her characteristics as a person, but rather in her additional knowledge of personality, her insight, and her ability to use her professional self wisely and effectively in helping other people.

The questions that should be asked about social welfare in 1961, as contrasted with 1900, are whether the recipients of its services are

About the Author . . .

Dr. Bornet is on the staff of the RAND Corporation, Santa Monica, Calif., a nonprofit research organization. A graduate of Emory University, he received a Ph.D. degree from Stanford University. Dr. Bornet has also written California Social Welfare: Legislation, Financing, Services, Statistics (1956) and many articles on historical and social subjects.

About the Reviewer . . .

A graduate of Colby College, Waterville, Me., in 1922, Mr. Mayo in 1942 was awarded by the College an honorary S.Sc.D. degree. From 1929 to 1934 he did graduate work in sociology and social work at New York University and the New York School of Social Work. He has a wide and varied experience in education and social work. In 1941 Mr. Mayo became dean of the School of Applied Social Sciences of Western Reserve University and in 1947 was named a vice president. Since 1950 he has been executive director of the Association for the Aid of Crippled Children. He is chairman of the U.S. Committee of the International Society for Rehabilitation of the Disabled and a member of the boards of the Child Welfare League of America, United Community Funds and Councils of America, the National Social Welfare Assembly, and the National Society for Crippled Children and Adults.

better served and whether the profession is making some impact on society. I think the answers are in the affirmative. Any method of helping people that recognizes and encourages their independence, and hence adds to their dignity while helping them to develop the means of self-help, is basically sound; there is evidence that modern social work operates on that basis and that in the last 50 years it has made substantial contributions to changes in society of lasting benefit to people at every economic level. I am not sure that Mr. Bornet quite enunciated the purpose, the philosophy, or the methods of modern social welfare and, particularly, that this profession is not exclusively for the poor but has a content and a method applicable to all people. If he did not see and feel this in his travels, it could be that social work has not yet learned how to express and reflect it adequately.

The author's comments with respect to the role of the government in social welfare are significant. The question is not so much "how far the government should go" in the development of welfare programs, as the author puts it, but rather, it seems to me, *what* the government should do and how it should operate.

The author objects to the argument that says in effect, "We are a rich society, and hence we should do more for people." No matter how much the government *can* do, he believes there should be a definite check on what it actually does in the welfare field, lest it make people dependent. This, of course, is an old and time-honored position.

Regardless of what the government can or cannot afford, the necessity remains, it would seem, for us to determine our moral and ethical obligations. If we look at the needs of people, ask how they can be met, to what

For Your Office Reference Shelf

IT IS APPARENT that the *Medical Almanac* has been compiled primarily as an informational aid for the practicing physician, who alone can best judge its usefulness to him. As a reference tool for other persons, it can be easily criticized by librarians for what has been included and what has been omitted. Both physicians and librarians, nevertheless, welcome this volume, the first of what is hoped will be a long line of annual or biennial editions.

Medical Almanac, 1961-62

Compiled by: **Peter S. Nagan**

1961. 528 p. tabs. W. B. Saunders Co., W. Washington Sq., Philadelphia 5, Pa. $5.00. Paperbound.

The opening section gives considerable information on the organization and officials of the American Medical Association and the state and metropolitan medical societies. This is welcomed by all, if for no other reason that this same information is so successfully hidden in the current issues of the *Journal of the American Medical Association* and the *American Medical Directory*. The sections relating to the financial affairs of physicians as businessmen may be useful to them but is likely to be consulted infrequently by other users.

Only usage of the volume will determine whether or not the sections on vital statistics, medical manpower, costs of illness, and hospital statistics will be consulted first here, ahead of *Statistical Abstracts of the United States; Health, Education, and Welfare Trends* (the annual volume and the monthly issues); and *Hospital Guide* (the August 1st issue of *Hospitals*). The volume also duplicates information on federal health agencies that is readily found in the *U.S. Government Organization Manual*. Giving space to postal rates and mailing regulations may be a convenience to physicians but such information can be found readily elsewhere, as sophisticated users of the *World Almanac* well know. In fact, these latter two inexpensive volumes belong as much in the office of any professional man as they do on the reference shelf of any library.

We are pleased that the statistics on diseases cover chronic and disabling conditions as reported by the National Health Survey, even though these are tabulated now in *HEW Trends*. Although federal agencies and medical societies and boards are well covered, such state agencies as Crippled Children's Services and Divisions of Vocational Rehabilitation are not. There is no directory listing of voluntary health agencies and professional associations in the paramedical fields. Rehabilitation facilities are not mentioned in any way. If these omissions are corrected in later editions, the directory sections of the volume will be vastly strengthened and will serve medical and social referral purposes. A medical almanac should be expected to include information on those state and community services of care and treatment that lie immediately adjacent to hospital care and medical practice.

Mr. Nagan, the compiler, makes a plea in his Preface for suggestions that would improve subsequent editions. It is earnestly hoped that users of this first volume, whether or not they are physicians, inform the compiler through his publisher what can be done to make this reference work indispensable.—*The Editor.*

extent funds are available to meet them, how tax and voluntary funds can be effectively used in co-operative efforts, and proceed on that basis, we are on the right track as a society with a conscience. Objective attempts to answer questions of this kind may possibly bring us out at the same point that Mr. Bornet reaches when he says that the government's role should be limited, but at least we would be arriving at the conclusion by way of a sounder route than the one that starts with the declaration "The government must not go too far."

Indeed, we should ask what is "too far." How far should a doctor or a hospital go in trying to make people well? There are limits to funds and personnel and to human ingenuity and wisdom, to be sure, but the sole high purpose of social welfare is to help people become independent and self-supporting. To whatever extent this is brought about, to that extent do those who have been tax burdens have a chance of becoming taxpayers; nowhere is this as evident as in the field of physical rehabilitation, where improvement can be measured and the statistics plainly seen. Every dollar well spent in restoration brings returns in increased independence and self-maintenance.

Should the government withhold funds that would rehabilitate a paraplegic and make him self-supporting? If not, then why not put more effort and dollars into the process of rehabilitating people who have emotional or social problems? The question to be asked then is "Why cannot the voluntary agencies *and* the government *together* go much further than they now do in restoration and rehabilitation?"

Fee charging is discussed at some length. I was sorry to see the chapter on this subject entitled "Fee-charging as Destructive Force," for there are highly constructive aspects to the fee-charging policy. Many of the pros and cons, however, are brought out during the discussion.

The chapter on fund raising gives a better appraisal of this complex problem than most current articles. It is easy to paint fund-raising federations as the cruel giants and the independent organizations as the little Davids with tiny sling shots. However, there is something slightly ludicrous in painting the American Cancer Society and the American Heart Association, not to mention The National Foundation, as anything but pretty husky giants in their own right! I think the author recognizes this and implies as much.

One hears reports now and then that federated fund-raising units "strong-arm" independent agencies in a community to bring them into the federation; one also hears reports of power moves by independent national voluntary health agencies. Both types of action must be regarded as completely out of character in welfare and health programs and are to be deeply deplored. The fact is that we have to learn the art of co-existence, and a philosophy of pressure and force is anathema to such a way of life. The tape-recorded interview with Walter Laidlaw, of the Detroit Community Fund, touching on some of these matters, was fascinating to read and is an excellent device for a study of this kind.

Other chapters in the book include the following: "The Anatomy of Social Welfare," "Voluntary Welfare: Its New Methods and Masters," "AFL-CIO Can Invigorate Voluntary Welfare," "On Radicalism, Pressure, and Planning," and "The American Pattern in Social Welfare."

It is useful for an intelligent observer and skillful writer to present an analysis of this kind and quality focused on a field other than his own. I found the book thoughtful and stimulating. It should furnish a good basis for discussion in many professional circles and certainly in schools of social work.

Other Books Reviewed

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The Application of External Power in Prosthetics and Orthotics; A Report on a Conference . . . September 22-25, 1960

Prepared by: **Committee on Prosthetics Research and Development, National Academy of Sciences-National Research Council**

1961. 156 p. illus., diag. Paperbound. (*Publ.* 874) National Academy of Sciences-National Research Council, Printing and Publishing Office, Washington 25, D.C.

BIOMECHANICAL PROBLEMS to be solved in future upper-extremity research were considered and recommendations made at the conclusion of the Conference, sponsored by the Committee. A review of the current status of research in the United States and other countries covered types of prostheses, their sources of power, control systems, kinesthetic aspects, and fitting and harnessing problems. The entire report, including orientation information, consolidated reports of panel discussions, general conference discussions, conclusions, and recommendations, offers a comprehensive view of achievements to date. Appendixes contain papers on electrical energy and compressed gases as sources of power, characteristics of the McKibben Artificial Muscle, pneumatic, hydraulic, and electromyographic control systems, and problems in the selection and fitting of prosthetic and orthotic devices in the ambulatory and wheel chair patient.

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California Legislature Report of the Senate Subcommittee on Housing and Recreational Needs of Elderly Citizens . . .

By: **Senate Subcommittee on Housing and Recreational Needs of Elderly Citizens, California Legislature**

1961. 130 p. tabs. Paperbound. Published by the Senate of the State of California and distributed by Miss Barbara Rosien, Co-ordinator, P.O. Box 17157, Foy Station, Los Angeles 17, Calif.

THE SECOND LEGISLATIVE Committee report supersedes one published in 1959 (see *Rehab. Lit.*, Sept., 1959, #705) and contains additional data, wider research findings, and added information on financing housing for the elderly. The six chapters covering the nature and scope of housing problems, licensing, building standards and zoning, recreation and leisure time activities (Chapter 4), findings of the Subcommittee on financing and housing plans, and the recommendations and conclusions have all been revised to discuss all aspects of the problems in greater detail. Chapter 4 is a completely new addition. For a digest of the section on health of the elderly, see #412, this issue.

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Exceptional Children; Residential Treatment of Emotionally Disturbed Boys at Shotton Hall

By: **F. G. Lennhoff** (Foreword by Dr. Edward Glover)

1960. 201 p. George Allen & Unwin, Ltd., Ruskin House, 40 Museum St., London, W.C.1, Eng. 21s (approx. $3.78).

LIFE AT SHOTTON HALL, a residential school in Shropshire, England, for 35 or 40 emotionally disturbed boys, aged 10 to 16, is regulated to meet the specific needs and problems of each child. Those accepted for treatment are of good intelligence and potential ability, considered fundamentally capable of good adjustment. Mr. Lennhoff states, in his introduction, that this account of daily life and treatment methods is "in no sense, a book on child psychology." However, his descriptions of the administration and physical facilities of the school and the means of coping with the boys' particular problems reveal an intimate knowledge of educational psychology and its practical application in the therapeutic community. Also discussed are the vital role of the lay staff in such schools and the need for personnel with highly specialized training. Material in the appendixes suggests useful administrative and staff training methods; included are: an educational psychologist's lecture on learning in the emotionally disturbed child; summary of a group discussion, led by a psychiatric social worker, which covered school problems; a suggested syllabus for a 14-month training course for housemothers; and forms used in recruiting personnel and reporting on individual progress of children under treatment. The book is filled with human interest accounts illustrating the success of various technics in working with maladjusted children.

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Les Feuillets de l'Infirmité Motrice Cérébrale

By: **Association Nationale des Infirmes Moteurs-Cérébraux**

(1961). various paging. figs. Published and distributed by Association Nationale des Infirmes Moteurs-Cérébraux, 57, Rue de Chateaudun, Paris (9e), France.

MEDICAL, PSYCHOLOGICAL, educational, and social aspects of a comprehensive treatment program for the cerebral palsied are covered in this manual, with text in French. Intended for use by medical and ancillary personnel working in the field, it contains discussions of the anatomy and physiology of the nervous system, the functions of muscles, physical examination and evaluation, psychological testing, diagnosis and classification, adjunctive therapies and equipment, surgical procedures used in cerebral palsy, and special education technics and materials. Illustrations of special equipment are from United States, British, and French sources; many are from the National Society for Crippled Children and Adults' *Cerebral Palsy Equipment* manual. Dr. Guy Tardieu, well known for his work with the cerebral palsied, contributed the main portion of the book.

Price of the publication was not quoted; those desiring additional information should write to the Association (address listed above).

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How To Live with Epilepsy

By: **Carroll Lunt**

1961. 196 p. Twayne Publishers, 31 Union Sq. W., New York 3, N.Y. $4.00.

AS FOUNDER AND PRESIDENT of the California Epilepsy Society until 1956 and the father of two epileptic sons, Mr. Lunt has intimate and firsthand knowledge of the problems seizures can cause in all areas of living. In his "layman's presentation" of those problems, he hopes to bring to parents, the epileptic person, medical students, and the general public a better understanding of the nature of epilepsy, its treatment, and the means available to help epileptics live a more normal life. The author covers a wide variety of problems and questions on marriage, parenthood for the epileptic, the responsibilities of parents of epileptic children, drivers' licenses, education and employment, segregation of adult epileptics,

inheritance of the condition, and the incidence of insanity among epileptics. Also discussed are the uses of psychiatric and social therapy, religion's contribution to mental health, and the resources available for aid. Lists of lay epilepsy organizations and of the major epilepsy clinics in the United States and Canada are included, with their addresses. The book should find wide use as an informative guide for all those wishing nontechnical coverage of the care and management of the disorder.

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Meals on Wheels for Old People

By: **Amelia I. Harris**

1960. 103 p. illus. Paperbound. The National Corporation for the Care of Old People, Nuffield Lodge, Regent's Park, London, N.W.1, Eng. 7s 6d ($1.35).

DATA FROM A SURVEY of more than 400 meals-on-wheels schemes known to be operating in England, Scotland, and Wales are analyzed in this Government Social Survey report, commissioned by the National Corporation for the Care of Old People, a voluntary organization in Great Britain. The investigation was designed to cover scope and administrative aspects of services, characteristics of recipients, the contributions made to their nutritional, economic, and social needs, cost of services, and how it is being met. Unmet needs and suggestions for improving and expanding services are discussed by the author, who spent two years on the survey. At present the service is provided mainly by voluntary organizations with some financial aid from local authorities; it is hoped that eventually such programs will be the responsibility of government bodies. The questionnaire forms used in the survey are included.

The National Corporation published only a limited supply of the report and advises that, should there be any demand from the United States, it might not be possible to supply all who request it. The report is summarized in *The Lancet,* Jan. 28, 1961, p. 235.

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The Nation and Its Older People; Report of the White House Conference on Aging, January 9-12, 1961

By: **U.S. Department of Health, Education, and Welfare, Special Staff on Aging**

1961. 333 p. Paperbound. Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C. $1.25.

IN ADDITION TO the conclusions, agreements, and courses of action determined as feasible for the solution of problems of the aging in the United States, the proceedings of the Conference contain background information on the origin, objectives, and planning on the national, state, and local level that preceded the meeting held in Washington, D.C., in January of this year. Policy statements and recommendations in Part III represent the work of conference delegates; the remainder of the report was prepared and edited by Clark Tibbitts and his associates. A variety of publications issued by federal and state agencies to provide background material for delegates is listed. The Department of Health, Education, and Welfare's Special Staff on Aging plans to issue a series of post-Conference publications under the general title "Reports and Guidelines from the White House Conference on Aging"; most of these will deal with specific subject-matter areas such as religion, housing, employment, research, and others.

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One of Those Children

By: **Elizabeth Neal**

1961. 198 p. George Allen & Unwin, Ltd., Ruskin House, 40 Museum St., London, W.C.1, Eng. 18s ($3.25)

SOME MOTHERS, CONFRONTED with the seemingly hopeless task of rearing a cerebral palsied child who the doctors said would never walk or talk and predicted would live only two or three years, might have given in to despair. But not Mrs. Neal! Although living was made even more difficult in England during the hardships of World War II, she was determined to give Barry every chance to prove experts, family advice, and uninformed bystanders wrong. This day-by-day account of her patient teaching and often ingenious methods of overcoming the boy's handicaps is not told in order to offer suggestions for the care and treatment of similar children. Her story should, however, be an inspiration to others faced with seemingly impossible odds. Today Barry is a happy and partially self-supported member of the community, although his mother is realistic enough to recognize his limitations and the fact that his future environment could undo her many years' work. Well written in almost a conversational style, the book does not minimize the difficulties of training and caring for a handicapped child but shows the author's philosophical acceptance of what needed to be done—and how she "got on with it."

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Play for Convalescent Children in Hospitals and at Home

By: **Anne Marie Smith**

1961. 183 p. *(rev. ed.)* A. S. Barnes and Co., 11 E. 36th St., New York 16, N.Y. $4.50.

A LONG OVERDUE revision of a book considered a classic in the field of recreational therapy since its original

publication in 1941, this book brings up to date theories of recreation and an expanded listing of play activities and materials to the attention of professional personnel, volunteers, and parents, who will welcome the ideas for home use. A section on play activities in clinics, based on experience in three Minneapolis Public Health Clinics and the Kenny Institute, has been added. Miss Smith organized the Department of Play at Chicago's Children's Memorial Hospital; the first edition of her book was an account of 6 years' experimentation with play with children under treatment and in the education of nurses receiving pediatric training. Discussed are the therapeutic value of play, the organization and administration of play programs, and the methods for using play in the instruction of nurses, volunteers, parents, and visitors. Tested forms of activities are classified by their suitability for bed patients and for solitary or group play. Play equipment appropriate as gifts to hospitalized children is suggested. An extensive bibliography and additional source material throughout the text provide comprehensive coverage of recreation for ill or handicapped children.

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Psychology and Education; Selected Essays

By: Hirsch Lazaar Silverman, Ph.D.

1961. 169 p. Philosophical Library, Inc., 15 E. 40th St., New York 16, N.Y. $3.75.

THIS IS A COLLECTION of the author's papers that have appeared in professional journals during the past 10 years. Chapter 8, "Psychological Diagnosis of the Exceptional Child" (p. 100-124), is based on his paper read before the Division of School Psychologists at the 1957 American Psychological Association convention in New York.

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Rehabilitation of the Physically Handicapped

By: United Nations Department of Economic and Social Affairs

1960. 76 p. illus., figs. (*Internatl. Soc. Serv. Rev.* Oct., 1960. No. 7) *(U.N. publ. ST/SOA/Ser.Q/7)* Available from United Nations, Sales Section, Publishing Service, New York, N.Y. $1.50.

REHABILITATION PROGRAMS and activities at the international level, their trends and emphases, and discussions of the administrative problems of the rehabilitation center, services for the blind in rural areas, physical therapy, and prosthetics, especially in underdeveloped countries, are included in this issue of the *Review*, the first since 1957 (see *Rehab. Lit.*, Aug., 1957, #1007) to be devoted to rehabilitation of the physically handicapped.

Contents: Introduction.—New trends and emphases in rehabilitation programmes, Howard A. Rusk.—Industrial accidents and their prevention, Marcel Robert.—Organization and functions of a small rehabilitation centre, Sidney S. Robbins.—The progress of physiotherapy in some of the economically less-developed regions of the world, M. J. Neilson.—Prosthetics in economically less-developed countries, Wilfred Kragstrup.—Pilot project for the rural blind in Uganda, Sir Clutha Mackenzie.—Selected bibliography on the rehabilitation of the physically handicapped.

Forthcoming

Featured as Article of the Month for July will be "A Report on the Epilepsy Problem," by George N. Wright, Ph.D. The author is national program director for the National Epilepsy League, Chicago.

Scheduled for early publication are the following articles:

"Operational Technics for Sheltered Work Programs," by N. P. Smith. The article reflects her practical experience in sheltered workshop supervision and in industrial production.

"Rehabilitation Aspects of Parkinson's Disease," by Robert S. Schwab, M.D., and Albert C. England, Jr., M.D. Dr. Schwab is director of the Brain Wave Laboratory, Massachusetts General Hospital; Dr. England is associated with Dr. Schwab at the Laboratory and affiliated with Harvard Medical School.

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

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Health of the Elderly

In: *California Legislature Report of the Senate Subcommittee on Housing and Recreational Needs of Elderly Citizens,* p. 24-27. 1961. 130 p. tabs. Issued by Subcommittee Chairman, Hugh M. Burns, State Senate, State Capitol, Sacramento, Calif. (See #402, this issue of *Rehab. Lit.*)

PROVISIONS FOR housing and recreation among the aged play a large part in maintaining their health. Pleasant surroundings, no matter how modest, foster the wholesome optimism that is the greatest blessing of a healthy old age. Who has not seen the self-sufficient elderly man or woman sent to an institution because of illness promptly deteriorate past possible return to the community? The aged's health is of prime importance to public authorities responsible for stretching the tax dollar.

Of California's population age 65 and over, 5 percent live in varied types of institutions, according to the State Department of Public Health. Of these 60,000 aged persons, about 2 out of 5 are in public institutions, the remainder in private institutions or in living arrangements for which the taxpayer meets all or part of the cost. Boarding homes and institutions for the aged house well over 25,000. According to the average for the year ending June 30, 1959, there were 220 licensed institutions for the healthy aged housing 16 or more, with a total capacity of 12,700, and 3,000 smaller homes (licensed for up to and including 15) with a capacity of 15,000. The boarding home for the well aged is important for elderly persons unable to live alone safely but who can be accommodated in a rather inexpensive type of shelter care, since institutionalization as such, with its much higher costs, is postponed.

In the health survey cited by *California's Older People* (California State Dept. of Public Health, 1959), 70 percent of the aged living in the community reported some kind of illness during the month preceding the interview—53 percent a chronic condition, 3 percent acute illness, and 14 percent a combination of acute and chronic illness. Findings of the survey confirm the belief that with increasing age days of disability increase for both sexes. The disability rate for the age bracket 75 and older is 3½ times higher than that for the population as a whole. Women required more days in bed than did men, and their rate rose steadily with age; men had a relatively static rate from middle years to age 75.

Most of the aged maintained a relatively high degree of activity, but a sharp rise in relative or complete disability occurred with increasing age. After 75, over half considered themselves limited to some degree by chronic conditions, almost a third saying they needed assistance to get around or carry on normal activities. For the aged illness can be a catastrophe. The number and severity of chronic conditions rise sharply after the middle years. *California's Older People* states that in those aged 65 to 74 chronic conditions average over 1.8 per person and in those over 75 about 2.3. Aging affects especially the incidence of certain chronic conditions and combinations of conditions such as cardiovascular diseases, arthritis and rheumatism, gastrointestinal conditions, and respiratory diseases. About one-tenth of men aged 65 and over have hernia. Older people seem increasingly prone to symptoms that cannot be classified into a disease category although mortality tables list them among the causes of death. Chronic respiratory ailments, allergies, skin diseases, and neuromuscular and bone diseases (other than arthritis and rheumatism) show no percentage increase after middle age but frequently persist for life.

The U.S. Public Health Service lists among principal causes of death among the aged cardiovascular-renal diseases, cancer-type diseases grouped as malignant neoplasms, and respiratory diseases including pneumonia and tuberculosis.

California's Older People states the aged average 2 days' hospital care a year, compared with 1 day for those aged 45 to 64 and considerably less for those under 45. Length of hospital stay averages 17 days for those over 65, 11 days for the 45-54 age group, and over 13 days for the 55-64 age group. In California, county hospitals provided about one-third of all general hospital days of care for those over 65.

In June, 1955, when the elderly were estimated at 8.1 percent of California's total population, nearly 29 percent of the state's mental hospital population was from this group—many may well have been admitted because "there was no place else to put them." In the setting of a mental hospital, the "well" person deteriorates rapidly. If the community does not help such persons remain in the

community, more and costlier mental and chronic disease hospitals must be built and supported by ever-rising budgets.

The aged have meager financial resources to care for their own medical costs. The percentage with insurance to give some protection from the economic drains of severe illness is rising but coverage declines with more advanced age, because policies are canceled when claims mount or because premiums can no longer be paid. Men are more often covered by insurance programs, possibly because as wage earners or union members more are able to take group coverage. Upon retirement such coverage may lapse or conversion to individual coverage may be beyond reach.

Over a quarter million aged are on California's Old Age Security (OAS) rolls with funds coming from federal, state, and county welfare budgets. Thousands more received assistance from other programs such as Aid to the Blind and General Assistance. Accurate information on the costs of all programs is not available. However, the cost to the state of California of the OAS from July 1, 1958, to June 30, 1959, was $110,249,740, with another $119,188,887 coming from the federal government and $18,375,456 from counties. How much of this almost one-quarter billion dollars went for housing cannot be determined but it must have been a substantial sum. Whether such allocations were enough to provide adequate housing for the elderly might be inferred from data in various sections of this report—whether its eventual effect was to *subsidize slums* is a question that should be answered.

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The Role of Educators in Evaluating Mentally Retarded Children

By: **Lloyd M. Dunn**, Ph.D. *(Coordinator of Special Education, George Peabody College for Teachers, Nashville, Tenn.)*

In: *Am. J. Mental Deficiency.* May, 1961. 65:6:796-800.

WHAT MAY BE DONE to improve medical and psychological diagnosis from a special educator's standpoint? What should educators contribute in the diagnosis of mental retardation?

An overview of the special educator's role is needed before going to these questions. The special educator is responsible for children with IQ's from 30 to 75, the educable and the trainable, with 50 the dividing line. The educable develop to adults with about 8 to 12-year levels intellectually and can be literate; regular school subjects and a life adjustment approach are emphasized. The trainable mature to mental ages of about 4 to 8 years and can develop rudimentary skills in self-care, socialization, and oral communication; these lesson areas are stressed.

By 1957-58, according to the U.S. Office of Education, 207,785 educable children were enrolled in schools, 196,785 in special classes in local school districts and 11,000 more in programs at residential facilities. Only 33,617 trainable children were served by special educators, 16,617 in day schools and 17,000 at residential facilities.

Medical and Psychological Diagnosis

The special educator feels a complete diagnostic work-up should include much more than determining mental retardation and whether a child is educable or trainable. Educators find reports from physicians and psychologists lack data needed for individualized, comprehensive educational programs. They believe physicians are primarily responsible for ruling out physical disability as the major handicap and ideally would like reports to give, in non-technical terms, more on biological characteristics. Merely reporting the possible cause of mental retardation and little more is of limited help. To improve medical reports facts are needed: visual characteristics of the child, acuity problems, muscular imbalance, perceptual dysfunctions, or problems of lateral balance; his auditory characteristics, with acuity and perceptual problems; circulatory, respiratory, or orthopedic disorders; and neurological conditions with any implications for learning. Biochemical data may affect plans for activities; the program may need to be modified for a child under sedation for seizures or hyperactivity. Endocrine dysfunction may have a bearing on programing.

Teachers regard the psychologist as mainly responsible for ruling out emotional disturbance as the chief disability and also for determining the degree of intellectual subnormality. Two major criticisms of the psychological report are: results of intelligence and personality tests do not alone totally assess psychological characteristics of the child; as a group psychologists give inadequate recommendations to the school. Teachers depend on individual intelligence test results in program planning and expect them from the psychologists. IQ and mental age scores are important. With a measure of school achievement, the teacher can plan according to the difference between capacity and achievement. Whether the psychologist should provide data on scholastic aptitude and achievement is an open question.

To improve psychological reports, data should be given on: personality characteristics and social adjustment; speech and language development; the child's social control and how he fits in with peers; and what he will do in various learning situations—his threshold for frustration, how he may react to types of positive and negative reinforcement, how he is best motivated, what his retentive characteristics are, how he goes about solving problems, what his attention span is in various settings. The special educator prefers a report free from psychological jargon, presenting data meaningful for school planning with realistic and helpful recommendations.

We are told physicians and psychologists lack instruments sensitive enough for such complete diagnostic examinations and educational recommendations, that they do not have time to gather such a mass of data. Therefore, the question arises: Should special educators assume a greater role in diagnosing mental retardation in aspects related to school programs?

Educational Diagnosis

An important service of the physician and psychologist is determining when a child is *ineligible* for a special education program for the mentally retarded because another physical or emotional disability is present. Another is evaluating retarded pupils' social and adjustment problems. Deciding if a child is *eligible* is an educational problem. The profession providing the treatment should make the final decisions on the feasibility of such treatment. *Special educators need to become skilled diagnosticians if they are to place and treat pupils effectively.* After eligibility is determined, placement must be decided on—in a nursery, primary, intermediate, or secondary group. A child's behavioral syndrome determines the type of program—conventional type for cultural-familial children, Lehtinen type in cases of Strauss type syndrome, Duncan type for the high performance, low verbal child, or other types.

Deciding on specific technics for the *individual* child requires skilled diagnosis. Reading characteristics determine the procedure used; knowledge of a child's hearing, speaking, reading, writing, and spelling vocabularies is desirable. Even more detailed analysis of his reading is advisable: comparison of a child's oral and silent reading and of his ability to name printed words and his comprehension of the passage; discovering his word attack skills, the extent of his sight vocabulary, his sound blending ability, his use of context clues, his phonetic word attack and ability to unlock words with it; and study of a child's eye movements, his experiential background, interests, and so on. A better selection of teaching method depends on an intensive clinical-educational approach based on a wealth of data.

Although special educators have expected to find such information in reports, psychologists cannot reasonably be expected to supply this diagnostic educational data. I submit their important functions are to consult with teachers on children's emotional problems, provide psychotherapy, and conduct research. Educators must assume full responsibility for all aspects of appraising school achievement, including specialized diagnostic testing on an individual basis of difficulties in subject matter areas. It is not so clear regarding measuring scholastic aptitude. However, it now appears that psychologists are prepared to turn over individual testing of intelligence, as they have group testing programs.

If we accept this position, it follows that colleges and universities preparing teachers of the mentally retarded should stress diagnosis more. Many experienced teachers with a year of specialized graduate study have had only one survey course in tests and measurements. Undergraduates majoring in both elementary education and education of the mentally retarded may not be able to take courses on diagnosis. At the graduate level as much as one third of the program could deal with diagnostic procedures. Teachers with graduate preparation would need to gain skills in individual intelligence testing. At the undergraduate level, teachers should be able to measure school achievement well enough so psychologists would not be called on for testing. Above all, graduate students need to learn how to administer diagnostic tests in the various skill subjects. The alternative is to develop a new type educator, an educational diagnostician, with all the skills of the psychometrician and additional diagnostic skills for studying educational disabilities. A few educators usually on the staffs of reading clinics and child study centers approximate this model.

The American Journal of Mental Deficiency is published bimonthly by the American Association on Mental Deficiency, with business offices at P.O. Box 96, Willimantic, Conn.; subscription rates: $3.00 per copy, $14.00 per volume.

(Continued from page 171)

44. Simmons, Ozzie G., and Davis, James A. Interdisciplinary Collaboration in Mental Illness Research. *Am. J. Sociol.*, 63:3:297-303, Nov., 1957.

45. Stanton, Alfred H., and Schwartz, Morris S. *The Mental Hospital.* New York, N.Y.: Basic Books, 1954.

46. Williams, Richard H. Hospital Aspects of Rehabilitation, p. 45-46, in: *Rehabilitation of the Mentally Ill,* edited by Greenblatt and Simon. Washington D.C.: Am. Assn. for Advancement of Science, 1959.

47. Williams, Richard H. Implications for Theory, p. 620-632, in: *The Patient and the Mental Hospital,* edited by Greenblatt, Levinson, and Williams. Glencoe, Ill.: Free Pr., 1957.

48. Wittkower, E. D., and Azima, H. Dynamic Aspects of Occupational Therapy. *A.M.A. Arch. Neurol. & Psychiat.*, 79:6:706-710, June, 1958.

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

ACCIDENTS—PREVENTION

See 485.

AMPUTATION—EQUIPMENT—RESEARCH

414. New York. University. College of Engineering. Research Division. Prosthetic Devices Study

(The NYU Field Studies of 1953-55). *Artificial Limbs.* Autumn, 1958. 5:2:1-128.

A companion number to the Spring, 1958, issue of *Artificial Limbs* (see *Rehab. Lit.*, June, 1959, #475), the current Autumn, 1958, issue presents the second half of the New York University Field Studies, extensive research on upper-extremity amputees and their prostheses.

Contents: Studies of the upper-extremity amputee: V. The armamentarium, Edward R. Ford and Earl A. Lewis—VI. Prosthetic usefulness and wearer performance, Hector W. Kay and Edward Peizer.—VII. Psychological factors, Jerome Siller and Sydelle Silverman.—VIII. Research implications, Sidney Fishman.

Another issue of *Artificial Limbs,* devoted to Syme amputations and prostheses, will be available in the near future (see July, 1961, *Rehab. Lit.*).

The journal is published twice yearly by the Prosthetics Research Board, National Academy of Sciences—National Research Council, 2101 Constitution Ave., Washington 25, D.C.

See also 401.

APHASIA

415. Hughes, Thomas M. *(VA Hospital, Memphis, Tenn.)*

Guidelines for aphasia. *Am. Arch. Rehab. Ther.* Mar., 1961. 9:1:4-10.

An educational therapist at the VA Hospital, Memphis, discusses the purpose, organization, and methods of aphasia therapeutics used in the hospital's speech therapy clinic. As teachers trained to instruct in the language arts, educational therapists could actively participate in the administration of speech correction programs for aphasics. Tables of data classifying 258 speech patients and results achieved or expected are included.

416. Schuell, Hildred *(5442 Edgewater Blvd., Minneapolis 17, Minn.)*

Relationship between auditory comprehension and word frequency in aphasia, by Hildred Schuell, James Jenkins, and Lydia Landis. *J. Speech and Hear. Res.* Mar., 1961. 4:1:30-36.

A report of a study exploring the ability of persons with aphasia to comprehend spoken words and the relative frequency of usage of words in the language. Word frequency appeared to be the most significant factor in predicting word comprehension as measured by the Ammons Picture Vocabulary Test with the 48 subjects. The clinician should be aware of the reduction in vocabulary in aphasic patients, in both speaking and comprehension. Comprehension of words tends to improve during the course of treatment in an orderly and predictable manner. The implications of the findings have importance in the approach to treatment.

APHASIA—DIAGNOSIS

417. Olson, James L. *(Dept. of Exceptional Education, Univ. of Wisconsin, Milwaukee, Wis.)*

Differential diagnosis: deaf and sensory aphasic children. *Exceptional Children.* Apr., 1961. 27:8:422-424.

Describes briefly a newly standardized test for young children, the Illinois Test of Language Ability, and its usefulness in differential diagnosis. Results of testing 25 deaf children and 27 with sensory aphasia are discussed. On 4 of the 9 subtests deaf children scored significantly higher than aphasics; differences were group differences, not differences between individual children. While not considered a definitive diagnostic tool, the test should provide useful information to the language clinician in some initial linguistic assessment situations. The article is based on a doctoral dissertation completed under the direction of Dr. Samuel A. Kirk, University of Illinois, in 1960.

APHASIA—NURSING CARE

418. Moser, Doris *(Massachusetts General Hosp., Boston 14, Mass.)*

An understanding approach to the aphasic patient. *Am. J. Nursing.* Apr., 1961. 61:4:52-55.

In working with the aphasic patient, the nurse should understand the degrees of impairment that can accompany different types of aphasia, the reactions she may expect from patients and their families, and how to establish temporary communication with the patient. The nurse can offer help and support in various ways, discussed in this article. Resources available for rehabilitation of the speech-impaired should be known by the nurse and the physician, in order to counsel with the patient and his family.

ARCHITECTURE (DOMESTIC)

See 402.

AUDIOMETRIC TESTS

419. Moss, James W. *(Univ. of Illinois, Urbana, Ill.)*

Electrodermal response to audiometry with mentally defective children, by James W. Moss, Margaret Moss,

and Jack Tizard. *J. Speech and Hear. Res.* Mar., 1961. 4:1:41-47.

Methods and results of a study to determine the extent to which mentally defective children could be conditioned with electrodermal response audiometry and how reliably the records could be interpreted are discussed. Findings indicated that EDR audiometry with such children is of limited value; the authors state it seems likely that most mentally defective children who cannot be tested by standard pure-tone methods probably cannot be tested by EDR audiometry.

BACKACHE

420. Anderson, Thomas P. *(Hitchcock Clinic, Hanover, N.H.)*

Post operative care in lumbar disc syndrome, by Thomas P. Anderson (and others). *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:152-158.

A review of results of a program of postoperative care in 179 patients who had undergone lumbar disc surgery. Of the group only 3% required fusion later and 94% appeared to have good results. The high percentage of favorable results is attributed to good surgical technics, careful preoperative evaluation, and individualized postoperative care. Individual treatment consisted of several or all of the following: exercises, posture correction, carefully controlled limitation of activities, treatment of associated disorders, gait corrections, and correction of occupational strains. The program is described in detail. Due to the scarcity of information in regard to postoperative care following disc surgery, this article should be a welcome addition to the literature.

BONES

421. Abramson, Arthur S. *(Albert Einstein Coll. of Medicine, New York 33, N.Y.)*

Influence of weight-bearing and muscle contraction on disuse osteoporosis, by Arthur S. Abramson and Edward F. Delagi. *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:147-151.

A critical review of the literature yields no unequivocal evidence that osteoporosis is reversible; therapy should be directed toward prevention and instituted as early as possible. Standing and ambulation (weight bearing) are much less effective than muscle action in preventing disuse osteoporosis but are probably not entirely ineffective in limiting the condition. Disuse osteoporosis and its resultant metabolic losses are self-limited; losses are greater with greater immobilization. Metabolic studies and therapeutic methods are discussed. 30 references.

BRACES

422. DeLorme, Thomas L. *(Massachusetts General Hosp., Boston 14, Mass.)*

An adjustable lower-extremity brace, by Thomas L. DeLorme (and others). *J. Bone and Joint Surg.* Mar., 1961. 43-A:2:205-210.

An illustrated and detailed description of the construction of an adjustable brace, of practical value in the evaluation and treatment of gait disturbances. The importance of the present brace is that it has demonstrated, in more than a year's clinical use, the technical feasibility of a quickly adjustable brace. Advantages and disadvantages of the device are discussed. In searching the literature, the authors were unable to locate any article on an effective adjustable brace.

423. Fuldner, Russell V. *(178 Sherman Ave., New Haven 11, Conn.)*

Lower extremity bracing in cerebral palsy. *Cerebral Palsy Bul.* 1961. 3:1:34-38.

Neurophysiological principles underlying concepts of treatment in cerebral palsy are reviewed briefly, as well as some general principles concerning approach to treatment. The role of bracing in cerebral palsy and the rationale for use of the Newington Brace for Cerebral Palsy (illustrated) are discussed. Although regarded only as an adjunct of treatment, bracing can be an aid in the inhibition and facilitation of movement, in the control of associated movements, and in balance training.

424. Nyquist, Roy H. *(VA Hospital, Long Beach, Calif.)*

Special appliances for the disabled. *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:164-166.

A description of a forearm brace with attachments for eating, writing, shaving, and brushing the teeth, an adaptation of the Georgia Warm Springs Foundation forearm long opponens hand splint designed for patients with spinal cord injury. Construction and design of the attachments are illustrated and described. Used by a quadriplegic patient with a lesion at the fourth, fifth, and sixth cervical vertebrae with about 55 to 60% function at the shoulder and elbow, the brace has improved self-care function to a useful degree.

See also 401.

BRAIN INJURIES—DIAGNOSIS

425. Vernon, McCay *(California School for the Deaf, Riverside, Calif.)*

The brain injured (neurologically impaired) deaf child; a discussion of the significance of the problem, its symptoms and causes in deaf children. *Am. Annals of the Deaf.* Mar., 1961. 106:2:239-250.

Academic, emotional, and physical symptoms of neurological impairment in brain-injured and deaf children are described and the possible causes examined. A high correlation of symptoms observed in both the deaf and brain-injured implies a much higher incidence of neurological impairment in the deaf than presently reflected in available statistics. Some psychological tests and test items useful in detecting brain injury in deaf children are discussed briefly. Two diagnostic forms based on the symptoms and causes of neurological impairment are included; their use would serve a threefold purpose in schools for the deaf, in statistical reporting, and in research.

BRAIN INJURIES—ETIOLOGY

426. De Haas, Karel J. *(Wrentham State School, Wrentham, Mass.)*

Enforced delay at delivery and its relationship to brain damage and mental deficiency, by Karel J. De Haas, Karl

V. Quinn, and Charles V. Pryles. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:610-614.

Data from a retrospective survey of histories of institutionalized mentally retarded children suggest that a causal relationship might exist between prolonged artificial delay of delivery during the second stage of labor and brain damage with mental deficiency. It is also suggested that a higher incidence of mental deficiency due to this cause may exist than was previously thought likely. Potential hazards of undue delay of delivery should be called to the attention of obstetricians and associated personnel. A detailed case history where the causal relation appears clear is included.

CEREBRAL PALSY

427. Bassa, D. M. *(School of Social Work [Nirmala Niketan], Bombay, India)*

Understanding the cerebral palsied child; some aspects of early management and diagnosis in infancy. *Indian J. Child Health.* Feb., 1961. 10:2:83-87.

Persistent symptoms, such as vomiting, crying, constipation, and inability to put on weight, unless they can be accounted for by a definite cause, must be considered suspect as indicating cerebral palsy, the more so if accompanied by maturational delay. In the early weeks of life hardly any physical signs of cerebral palsy are present; the condition can be diagnosed neurologically by the fourth or fifth month, at the earliest, Dr. Bassa believes. Early awareness of these symptoms as a sign of possible cerebral palsy aids in diagnosis and rehabilitation and promotes better child-parent relationships.

See also 404; 408; 423; 470.

CEREBRAL PALSY—MENTAL HYGIENE

428. Denhoff, Eric *(293 Governor St., Providence 6, R.I.)*

Emotional and psychological background of the neurologically handicapped child. *Exceptional Children.* Mar., 1961. 27:7:347-349.

The role of hereditary, environmental, and psychological factors, organic brain dysfunction, and sensory deprivation in the emotional and psychological make-up of the neurologically handicapped person must be recognized by the physician involved in total care of such children. His duty is to help the family and the child make realistic adjustments; he must begin, Dr. Denhoff believes, by trying to establish functional efficiency in the child. Goals in total care must be based upon physical efficiency, intellectual adequacy, and emotional stability.

CEREBRAL PALSY—RESEARCH

429. Miller, Brewster S.

Neurological and rehabilitation research potential in Europe; a report of a short trip taken July 1st to 27th, 1960. . . New York, Internatl. Soc. for Rehabilitation of the Disabled (1961). 74 p. Mimeo.

A report of a 27-day trip to 9 European countries, sponsored by the International Society for Rehabilitation of the Disabled, the World Federation of Neurology, and World Rehabilitation Fund, which provided Dr. Brewster, medical director of United Cerebral Palsy Associations, the opportunity to investigate various rehabilitation facilities and the potentials for neurological research in Europe. It is hoped that the findings and recommendations may lead to collaborative study of the effectiveness of various methods used in the treatment of cerebral palsy. Current research projects in the various countries, services provided for rehabilitation, and the organization and administration of services are summarized. Dr. Brewster also reports on the London Conference on the Scientific Study of Mental Deficiency, held in July, 1960. In addition, a concise report on the history of the Belgian National League of Cerebral Palsy Patients and a summary of selected current research in cerebral palsy and mental retardation, undertaken in the U.S., are included.

The report was issued by the International Society for Rehabilitation of the Disabled, 701 First Ave., New York 17, N.Y.

CEREBRAL PALSY—SPEECH CORRECTION

430. Ingram, T. T. S. *(Univ. of Edinburgh, Edinburgh, Scot.)*

A description and classification of common speech disorders associated with cerebral palsy, by T. T. S. Ingram and Jane Barn. *Cerebral Palsy Bul.* 1961. 3:1:57-69.

From an analysis of examination results in 258 children with cerebral palsy seen in the Speech Clinic, Royal Hospital for Sick Children, Edinburgh, the writers classified speech disorders found associated with various forms of cerebral palsy. Classifications of speech defects and of cerebral palsy, found useful in Edinburgh clinics, are described. The establishment of an acceptable classification of speech disorders is essential for accurate diagnosis; it should comprehensively cover anatomical, neurological, and psychological aspects of speech disorders.

Other articles in this issue of the *Bulletin* that deal with speech and hearing problems include: Hearing and speech disorders, O. L. Zangwill, p. 3-4.—Delayed sensory feedback in the study of defective speech and writing, H. Kalmus, p. 5-6.—The child's hearing for spoken language, Mary D. Sheridan, p. 39-45.—Hearing and speech disorders in childhood, Gavin Livingstone, p. 46-51.—Hearing and speech disorders, Michael Reed, p. 52-56. Mr. Zangwill's brief article summarizes the content of the other five articles.

CHILDREN (DEPENDENT)

431. Fanshel, David *(Child Welfare League of America, 345 E. 46th St., New York, N.Y.)*

Specializations within the foster parent role; a research report: Part II. Foster parents caring for the "acting out" and the handicapped child. *Child Welfare.* Apr., 1961. 40:4:19-23.

In same issue: The hard-to-place child, Jane Edwards. p. 24-28.

Factors related to ability of foster parents to provide high level care for physically handicapped, mentally retarded, or emotionally disturbed children were analyzed in a study of 101 families rated by social caseworkers as best able to undertake this type of placement. Characteristics of foster parents able to care for each type of child are discussed. The data reported here and in the first part of the article (*Child Welfare,* Mar., 1961) suggest meaningful dimensions for categorizing foster

parents in the roles to which they are best suited.

Miss Edwards *(Spence-Chapin Adoption Service, 6 E. 94th St., New York 28, N.Y.)*, supervisor of foster care services of an adoption agency, describes technics used in finding foster homes for children difficult to place in adoptive homes. Physically handicapped children, those with medical problems, and children of minority groups (unusual racial or nationality admixture) present the greatest placement problems.

CHRONIC DISEASE—INSTITUTIONS

432. Modern Hosp. Apr., 1961. 96:4:99-115.

Special section on nursing homes.

Contents: Nursing home is at the hospital's doorstep, William A. Deems.—These nursing homes stress activity, Philip A. Austin.—New legislation will aid nursing homes, John J. Sparkman.—This home takes aged "off the shelf," *(St. Joseph's Manor, Trumbull, Conn.)*.—How to plan and finance a nursing home, Donald G. Nash.

Discussed in this series of articles are: A nursing home facility operated as a branch of a general hospital; prototype plans for 62 and 44-bed nursing homes to restore long-term patients to maximum self-efficiency; plans of the Senate Small Business Committee to raise standards and increase the number of nursing homes; a facility that provides a casual, friendly environment without rules and routines; and tips to prospective owners on selection of location and organization of the home on a business-like basis.

433. Underwood, Bruce *(U.S. Dept. of Health, Education, and Welfare, Washington 25, D.C.)*

Environmental health needs in nursing homes. *Am. J. Public Health.* Apr., 1961. 51:4:531-535.

Easily understood educational material, consultative assistance, training for nursing home staffs, on-the-job technical assistance, and regulation, preferably by a qualified local health department, are suggested as approaches to the improvement of nursing homes and their services. Some specific criteria for a functional, safe, and sanitary environment in nursing homes are discussed.

This article is one of four included in a section on environmental health needs in medical, paramedical, and educational institutions. Others are: The factor of institutional living in the nation's health, L. S. Goerke, p. 517-523.—Environmental health needs in colleges and universities, Richard G. Bond (and others), p. 523-530.—Environmental health needs for hospitals and medical centers, Lawrence B. Hall (and others), p. 535-541.

CLEFT PALATE—SPEECH CORRECTION

434. Morris, Hughlett L. *(University Hosp., Iowa City, Iowa)*

An articulation test for assessing competency of velopharyngeal closure, by Hughlett L. Morris, D. C. Spriestersbach, and Frederic L. Darley. *J. Speech and Hear. Res.* Mar., 1961. 4:1:48-55.

Reports the development of the Iowa Pressure Articulation Test, used for assessing adequacy of oral pressure for speech sound production, and, inferentially, the adequacy of velopharyngeal closure. Test items containing fricatives, plosives, and affricates were found best for discriminating between speakers with adequate and inadequate closure. Results of the study are generally consistent with other research findings.

CONVALESCENCE—RECREATION

See 409.

DEAF—ETIOLOGY

See 425.

DEAF—SPECIAL EDUCATION

435. O'Connor, Clarence D. *(904 Lexington Ave., New York, N.Y.)*

The integration of the deaf in schools for the normally hearing. *Am. Annals of the Deaf.* Mar., 1961. 106:2: 229-232.

An analysis of data from intensive study of 18 pupils of the Lexington School for the Deaf, New York City, who were transferred to regular school classes reinforced views consistently held by Lexington School personnel in determining pupils' potential for successful transfer. Factors affecting integration of deaf children into regular school classes are examined and some guidelines are offered parents. This article appeared in the School's *Parents Newsletter*, June, 1960.

See also 491.

DIABETES

436. New Jersey State Department of Health *(Trenton 25, N.J.)*

Long range control of diabetes (papers . . . presented at a Diabetes Training Conference . . . November 2, 1960. . . .) *Public Health News*, N.J. State Dept. of Health. Apr., 1961. 42:4:99-127.

Contents: Diabetes control; a medical and public health problem, Arthur Krosnick.—Medical problems associated with diabetes, Arthur Krosnick.—Where are the diabetics? Miriam Sachs.—Visual problems of the diabetic, Alfonse A. Cinotti.—Emotional problems of persons with diabetes mellitus, Stanley R. Kern.—Care of feet of diabetic patients, Raymond K. Locke.—Nursing as it relates to diabetes, Patricia Hanna.—Role of social work in care of diabetic patients, Eileen English.—Nutrition and the diabetic patient, Winifred C. Sullivan.—Educational aspects of diabetes control, Evelyn Rahm.—Community organization for diabetes detection, Gertrude Eckhardt.—Diabetes case-finding in New York City, Irving Greenwald.

The Training Conference, sponsored by the Diabetes Control Program and the Metropolitan State Health District of the New Jersey State Department of Health, was attended by professional and voluntary public health and hospital personnel.

EMPLOYMENT (INDUSTRIAL)—PLACEMENT—GREAT BRITAIN

437. Zinovieff, A. *(Dryburn Hospital, Durham, Eng.)*

The work of a hospital resettlement clinic. *Annals Phys. Med.* Feb., 1961. 6:1:17-22.

Describes the organization and administration of a

hospital resettlement clinic, started in 1951, that serves one orthopedic hospital, two general hospitals, and a population area of approximately 130,000. The monthly clinic, attended by the physician in physical medicine at Dryburn Hospital, disablement resettlement officers, the social worker, and the superintendent occupational therapist, sees an average of three patients at each meeting. Resettlement plans are worked out by the clinic team and discussed in personal interviews with patients. Follow-up of previous patients is also undertaken until resettlement is achieved. Results with 91 patients seen over a 3-year period are discussed; resettlement was successful in 60% of cases, with 83% of the group still employed at follow-up. Some problems of resettlement are discussed.

EPILEPSY

See 405.

EPILEPSY—DIAGNOSIS

438. Balthazar, Earl E. *(Caro State Hosp. for Epileptics, Caro, Mich.)*

The use of Wechsler Intelligence Scales as diagnostic indicators of predominant left-right and indeterminate unilateral brain damage, by Earl E. Balthazar and Don H. Morrison. *J. Clinical Psych.* Apr., 1961. 17:2:161-165.

A report of a study investigating the possibility of establishing a cutting score for differences between the weighted verbal and performance scale IQ's, which then could be used as an aid in neuropathic diagnosis. The validity of diagnoses of predominantly left-sided, questionable or indeterminate, or predominantly right-sided lateralization made in 96 chronically organic epileptic patients at a state hospital was evaluated, using the electroencephalogram as a criterion. Of the subjects, 64% were correctly classified by the Wechsler difference score, an improvement of 25% over that expected due to chance in this population. Differences between subtest means in the three groups were evaluated and found to be similar to those reported in previous studies.

See also 444.

EPILEPSY—SPECIAL EDUCATION

439. Eisner, Victor *(Univ. of California School of Medicine, San Francisco, Calif.)*

Epilepsy in the classroom, by Victor Eisner and George H. Schade. *Elementary School J.* Apr., 1961. 61:7:384-387.

Two physicians offer advice to teachers on placement, day-to-day classroom management, and complications arising in children with epilepsy. The teacher who understands the symptoms of various types of seizures is more able to handle the situation to the best interests of the child and his classmates. Since more than 80% of patients with epilepsy do not have seizures while under proper medication, more of these children will be assigned to the regular classroom.

HEART DISEASE

440. Newman, Louis B. *(333 E. Huron St., Chicago 11, Ill.)*

Total rehabilitation in heart disease. *J. Am. Med. Assn.* Apr. 15, 1961. 176:2:114-117.

Comprehensive rehabilitation services, instituted in the early stages of heart disease, can successfully return most patients to useful, productive living. Physical medicine and rehabilitation activities should be integrated with medical care; the total care program can result in improved mental and physical well-being, through elimination of anxiety and other psychological complications. Basic objectives in the rehabilitation of patients with heart disease are outlined. Social service and vocational rehabilitation will be needed in those cases where patients are unable to return to their former type of employment. Periodic reviews of the patient's medical condition and work environment are essential.

HEART DISEASE (CONGENITAL)—ETIOLOGY

441. Campbell, Maurice *(Cardiac Dept., Guy's Hosp., London, Eng.)*

Place of maternal rubella in the aetiology of congenital heart disease. *Brit. Med. J.* Mar. 11, 1961. 5227:691-696.

Numerically, maternal rubella is not one of the major causes of congenital heart disease, in the author's opinion, even though it is one of the best-proved causes. A review of the literature is given. Dr. Campbell also considers the risk to the child after maternal rubella in pregnancy, which malformations are most common when the heart is affected, the proportion of congenital heart disease attributed to maternal rubella, and the importance of other viral or bacterical infections in producing congenital heart disease.

HEMIPLEGIA

See 473.

HOMEBOUND—NURSING CARE

442. Michigan. Department of Health *(Lansing 4, Mich.)*

Focus on home nursing care, by Julia Brandeberry. *Michigan's Health.* Mar., 1961. 49:3:19a-22d.

Medical care legislation passed in Michigan last September promises home nursing care for 60,000 old age assistance recipients as they need it. A bill currently pending seeks to add such services to the hospital and physician services for all persons over 65 who, under a means test, cannot afford medical bills. If passed, another 60,000 persons would be eligible. Problems in the expansion of services into areas where none exist are discussed. Recommendations adopted by local health department directors attending the annual state health conference are included; four methods of providing part-time home nursing care in Michigan are discussed. Examples of special experimental programs illustrate organizational possibilities.

Reprints of the article are available from the Department.

See also 406.

LARYNGECTOMY

443. Gardner, Warren H. *(2020 E. 93rd St., Cleveland 6, Ohio)*

Aids and devices for laryngectomees, by Warren H. Gardner and Harold E. Harris. *Arch. Otolaryngol.* Feb., 1961. 73:145-152.

An estimated 40% of patients who survive surgical removal of the larynx never acquire intelligible esophageal speech. A realistic attitude should be adopted regarding their needs; they should be informed of the wide variety of aids available. Discussed are: a comprehensive rehabilitation program for laryngectomees, the role of "lost chord" clubs in encouraging laryngectomized patients to learn to speak again, and adaptations in dress and personal hygiene. Case histories of eight patients illustrate a variety of problems experienced by laryngectomees and some of the solutions.

LATERALITY

444. **Perria, Luigi** *(San Martino City Hosp., Genoa, Italy)*

Determination of side of cerebral dominance with amobarbital, by Luigi Perria, Guido Rosadini, and Gian Franco Rossi. *Arch. Neurol.* Feb., 1961. 4:2:173-181.

The authors report results of a study on 30 adult patients who were subjected to carotid angiography. All patients had cerebral neoplasms, seizure disorders, or cerebrovascular diseases of differing natures. Changes in EEG activity, motor power, superficial plantar reflex, knee jerk, speech ability, and emotional state were checked following injection of sodium amobarbital. The technic is considered useful in neurosurgical practice. The presence or absence of speech defects and the development of an emotional reaction of the depressive or euphoric type after the injection are signs directly indicating whether the drug has interfered with the function of the dominant or the nondominant hemisphere. 13 references.

See also 438.

LIBRARY SERVICE

445. **ALA Bul.** Apr., 1961. 55:4:313-349.

Title of issue: Hospital and institution library service.

Contents of the special section on hospital and institution library service: Full partnership on the educational and therapeutic team, Clara E. Lucioli.—Reading as therapy, Karl Menninger.—Library services to the blind and other handicapped groups, Emerson Greenaway.—Philadelphia team; Free Library and Youth Study Center, E. Preston Sharp.—Library service to state institutions, Eloise Ebert.—Trends in hospital library service, Helen Pruitt Swift.—The case for a hospital library, Juanita Ziegler Wiles.—Notes on education for hospital librarianship, Henry J. Gartland.—Hospital library service; a selected bibliography, Marie Peltier and Helen T. Yast.

MEDICINE (INDUSTRIAL)

See 475.

MENTAL DEFECTIVES—DIAGNOSIS

446. **Cantor, Gordon N.** *(Iowa Child Welfare Research Station, State Univ. of Iowa, Iowa City, Iowa)*

Some issues involved in Category VIII of the AAMD Terminology and Classification Manual. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:561-566.

A paper presenting in slightly modified form the content of an address given at a regional meeting of the American Association on Mental Deficiency in October, 1960. The controversial nature of the five specific codes included in Category VIII of the Association's classification manual (dealing with "mental retardation due to uncertain [or presumed psychogenic] cause with the functional reaction alone manifest") is considered. Dr. Cantor's discussion centers on two major issues raised by Drs. Garfield and Wittson in their article appearing in the May, 1960, issue of *Am. J. Mental Deficiency.*

447. **Orr, Thomas B.** *(Ft. Wayne State School, Ft. Wayne, Ind.)*

Inter-judge agreement on the behavioral scales of the new AAMD classification manual, by Thomas B. Orr and Charles G. Matthews. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:567-576.

Three psychologists and a social group worker served as raters in the classification of case records of 50 mentally retarded residents of a state institution. The nine behavioral scales of the new AAMD classification manual were used. The generally unsatisfactory interjudge agreement shown in this investigation appeared to be attributable primarily to two general sources—ambiguously defined scales and scale points and/or inadequate or inappropriate data to be rated. Judges commented that scale definitions lent themselves to diverse interpretations and needed further refinement. Similar studies in various settings are needed to determine which shortcomings of the manual emerge consistently.

See also 413; 419.

MENTAL DEFECTIVES—EMPLOYMENT

448. **Dinger, Jack C.** *(Altoona School District, Altoona, Pa.)*

Post-school adjustment of former educable retarded pupils. *Exceptional Children.* Mar., 1961. 27:7:353-360.

Analysis of the postschool achievements of 100 former pupils of Altoona's special education program for the educable retarded, currently employed and residing in the city, indicated that positive adjustments *can* and *are* being made. Interviews with the subjects and their employers yielded data on educational and military experiences and attitudes, occupational histories, material and financial status, degree of participation in community affairs, and leisure time activities. Conclusions in regard to occupational, economic, and social adjustments within the group are given. Recommendations are offered for an improved curriculum for future retarded pupils and include suggested units of training to be used in the final year of high school, to help the retarded deal with adult community living problems.

449. **Meadow, Lloyd** *(4349 Glendale, Detroit 38, Mich.)*

Employability of lower level mental retardates, by Lloyd Meadow and Eugene Greenspan. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:623-628.

A report of results of a one-year pilot research project at the Jewish Vocational Service of Detroit, to test the feasibility for vocational rehabilitation of 10 low level retardates. Discussed are population characteristics, diagnostic findings, the workshop program and its results, and results of final testing on the same battery of tests

used initially. The project demonstrated the positive influences of an intensive sheltered workshop on low level retardates, many of whom achieved personal gains and the ability to function in a permanent workshop program. Few, however, could ever sustain themselves in competitive employment.

450. Warren, Fount G. *(Kent County Dept. of Special Education, Grand Rapids, Mich.)*

Ratings of employed and unemployed mentally handicapped males on personality and work factors. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:629-633.

Further data from a research project at Southern Illinois University (see *Rehab. Lit.*, Sept., 1960, #686) are presented. This phase of the investigation attempted to assess the importance of certain specific and/or general factors to employment of the mentally handicapped. Validation of the rating scale used in the project was tested. The rating sheet form, covering personality and social adjustment factors, work habits, and efficiency factors, is illustrated. Analysis of results of its use with 38 subjects enrolled in the project are tabulated; the scale is believed to be a useful predictor of potential employment.

MENTAL DEFECTIVES—ETIOLOGY

See 426.

MENTAL DEFECTIVES—MENTAL HYGIENE

451. Pilkey, Loraine *(1921 W. 48th Terrace, Kansas City 12, Mo.)*

Psychodrama and empathic ability in the mentally retarded, by Loraine Pilkey, Morton Goldman, and Bernard Kleinman. *Am. J. Mental Deficiency.* Mar., 1961. 65:5: 595-605.

Procedures and findings of a research project to determine the possibility of improving empathic ability in retarded adolescents through psychodrama training are discussed. This study gives some support to the value of the technic in therapeutic work with subnormal adolescents in a public school system. Improvements in self-perception and ability to predict responses of others were evident at a level of significance in over half the traits examined.

MENTAL DEFECTIVES—OCCUPATIONAL THERAPY

452. Brower, Lester M. *(7115 Arkansas Ave., Hammond, Ind.)*

The occupational therapist's role with mentally retarded children. *Am. J. Occupational Ther.* Mar.-Apr., 1961. 15:2:61-62.

Occupational therapists are definitely justified in working with the retarded child, directly in the treatment center or guiding parents or teachers in the home, classroom, or sheltered environment. Skills the therapist can teach—social, physical, or vocational—are needed by the retarded if maximum potential is to be developed. The trainable or dependent child, especially, can benefit from the type of training the therapist is prepared to give.

MENTAL DEFECTIVES—PERSONNEL

See 482.

MENTAL DEFECTIVES—PREVENTION

453. Kratter, Frederick E. *(30 Harold St., Prestwich, Manchester, Eng.)*

Negative and positive eugenic programs for mental defectives. *J. General Psych.* 1960. 63:203-210.

Legal measures for the socioeconomic and moral control of the mentally defective are viewed as less desirable than programs of medical care, training, and education. The difficulties of administering such laws without discrimination are considered. The writer suggests a positive eugenic program aimed at increasing the number of persons above medium intelligence; national social policies in England and other countries toward this end are discussed briefly.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

454. Enos, Francis A. *(Wisconsin Diagnostic Center, 1552 University Ave., Madison, Wis.)*

Emotional adjustment of mentally retarded children. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:606-609.

In a study of the relationship between intelligence and emotional adjustment in 120 fourth grade public school children, girls, as a group, were better adjusted than boys. Among girls, those rated superior were making the best adjustment; those with low IQ were most maladjusted. Among boys, slow learners were making the best adjustment, while boys of average intelligence showed the greatest incidence of emotional maladjustment. Children were equally divided by sex into three intelligence groups—the educable mentally retarded, average, and superior. Data used in this report are from a 3-year Health, Education, and Welfare research project, No. 153, under the direction of Herbert J. Klausmeier (see *Rehab. Lit.*, Sept., 1960, #664, for reference to articles on various phases of the research project).

See also 483.

MENTAL DEFECTIVES—SURVEYS—MISSOURI

455. Caldwell, Bettye M. *(Upstate Medical Center, State Univ. of New York, Syracuse, N.Y.)*

Reactions of community agencies and parents to services provided in a clinic for retarded children, by Bettye M. Caldwell, Edward J. Manley, and Yael Nissan. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:582-589.

In same issue: Factors associated with parental reaction to a clinic for retarded children, by Bettye M. Caldwell, Edward J. Manley, and Barbara J. Seelye. p. 590-594.

Analysis of replies to a questionnaire survey of community agencies and parents of children served by a community-supported clinic established at Washington University School of Medicine revealed attitudes toward the adequacy of services. This type of evaluation procedure is recommended for inclusion as a standard part of the operational procedure in clinics serving the retarded. Methods of the investigation and the type of information sought are discussed; reactions of both agencies and parents are summarized.

The second article (p. 590-594) reports analysis of questionnaire results from 88 parents in the survey discussed above. Main results indicate that intrafamily vari-

ables are more influential in determining parental reaction than are the selected clinic variables.

MENTAL DISEASE

456. Gelb, Lester A. *(55 E. 86th St., New York 28, N.Y.)*

Personality disorganization camouflaged by physical handicaps. *Mental Hygiene.* Apr., 1961. 45:2:207-215.

Many instances of serious mental disturbance not previously recognized have been uncovered during evaluation of physically disabled or chronically ill patients seen at the Institute for the Crippled and Disabled, New York City. Dr. Gelb considers the probability that degree of disability is enormously magnified by unrecognized mental illness; the psychological dynamics of the role and value of physical disability to the mentally disturbed patient are discussed. Five case histories illustrate psychological reactions to disability, the effect of psychic trauma, and the use of symptom components of disability to express pre-existing personality or as a cover-up for primary mental illness. In the comprehensive rehabilitation setting psychiatric evaluation and psychotherapy can aid in recovery.

See also p. 166.

MENTAL DISEASE—EMPLOYMENT

457. Wolfe, Harvey E. *(3816 Barker Rd., Cincinnati 29, Ohio)*

A survey of vocational rehabilitation at Longview State Hospital for 1959. *Mental Hygiene.* Apr., 1961. 45:2:167-170.

Results of a vocational rehabilitation program at Longview State Hospital, Cincinnati, during 1959, the first calendar year during which comprehensive services were provided, are analyzed. Types of work therapy assignments, assignments prior to job placement, competitive job and sheltered workshop placements, and patient characteristics are discussed. Vocational rehabilitation, to be successful, must involve the patient, hospital staff, and community in a continuous, meaningful experience. Administration of the program at Longview is described briefly.

MENTAL DISEASE—PSYCHOLOGICAL TESTS

458. Blustein, Herman *(VA Hosp., Downey, Ill.)*

The evaluation of psychiatric recovery; the Social Adaptability Test. *Am. J. Occupational Ther.* Mar.-Apr., 1961. 15:2:63-66, 82.

Describes a 56-item test covering three broad categories —speech, behavior, and personal appearance, designed for use by physical medicine and rehabilitation therapists to measure recovery in the neuropsychiatric patient. Social adaptability, as used here, refers to the degree of a person's emotional tolerance for different physical activities and environmental hazards the patient may encounter personally, occupationally, or socially. Methods for using the specific evaluation of a person's abilities and degree of emotional fitness for human activities in determining future plans for rehabilitation are discussed. Test forms are illustrated.

MENTAL HYGIENE

459. Miller, Milton H. *(1300 University Ave., Madison, Wis.)*

Continuing incapacity despite "medical recovery." *J. Am. Med. Assn.* Apr. 22, 1961. 176:3:205-207.

In spite of good medical or surgical recovery, many patients continue to be incapacitated; this is especially apt to occur in patients long immobilized and dependent upon others for care. Doctor-patient relationships and the physician's interest and ability to understand patients' needs influence the course of recovery. Discharge planning should be started with the physician's initial contact with the patient; adjunctive measures to keep the patient alert, stimulated, and self-confident should be considered. Awareness of existing rehabilitation facilities and their utilization in promoting recovery is necessary. Factors responsible for failure to achieve recovery are illustrated with case histories.

MUSCLES

460. Roasenda, Julio P. *(Kenny Rehabilitation Institute, Minneapolis, Minn.)*

A review of the physiology, measurement and management of spasticity, by Julio P. Roasenda and Paul M. Ellwood. *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:167-174.

This summary of the present knowledge concerning the physiology, measurement, and surgical and nonsurgical treatment technics in spasticity includes a short historical résumé of many investigations in the field. An evaluation of drugs to reduce spasticity is made. The authors emphasize the need for careful, frequent clinical observations, which they consider superior to any mechanical or electronic devices for measuring spasticity. Relative effectiveness of any form of treatment can be expected to vary greatly in different individuals. Early effective nursing and physical therapeutic measures designed to control afferent stimuli are suggested for optimal results. Further studies on physiology and measurement are needed before definitive conclusions can be made.

MUSCLES—TESTS

461. Iddings, Dorothy M. *(4514 Viking Dr., Houston, Tex.)*

Muscle testing: Part 2. Reliability in clinical use, by Dorothy M. Iddings, Laura K. Smith, and William A. Spencer. *Phys. Therapy Rev.* Apr., 1961. 41:4:249-256.

Validity of the manual muscle test, described in Part 1 of this article (see *Rehab. Lit.*, May, 1961, #369), was studied to determine its usefulness in clinical testing. Three studies, in which 13 physical therapists participated, were conducted. Results of examiners' gradings of muscle strength in individual muscles are analyzed and factors affecting variability of grading are discussed. Results were found to be relatively consistent when analyzed in terms of individual muscle grades, regardless of the method of comparison. Findings indicate manual muscle testing used in clinical situations can be highly reliable despite differences in training of therapists and use of different technics of testing.

462. **Miglietta, Osvaldo E.** *(New York Med. Coll., 1 E. 105th St., New York 29, N.Y.)*

Application of the stretch and Hoffman reflexes to the objective measurement of spasticity, by Osvaldo E. Miglietta and Milton Lowenthal. *Arch. Phys. Med. and Rehab.* Apr., 1961. 42:4:258-264.

Describes two methods used in the objective and quantitative assessment of activity of the anterior horn cells. The technics, tested under clinical conditions, are simple, easy to perform, and results are easily interpreted; an added advantage is the minimal stress placed on the patient. Both methods make use of the reflex-induced action potential response in muscles as a means to measure excitability of the spinal motor neurons in spasticity. Discussed are the neurophysiologic factors involved, the technical features of the methods, and their application in the clinical setting.

See also 467; 471.

NEPHROSIS

463. **Heymann, Walter** *(2103 Adelbert Rd., Cleveland 6, Ohio)*

Importance of early treatment of the nephrotic syndrome, by Walter Heymann and Janet L. P. Hunter. *J. Am. Med. Assn.* Feb. 18, 1961. 175:7:563-568.

A review of the results achieved over a 5-year period in treating 63 children with long-term steroid therapy. The rate of serious complications has diminished with the use of prednisone or triamcinolone; Cushing's syndrome and inhibition of growth in different degrees of severity were noted but these effects of therapy have always been reversible. Degree of severity seemed to depend upon the individual child's susceptibility. Evaluation of treatment by number of hospital admissions or by length of needed steroid therapy to maintain protein-free urine suggests early therapy favors satisfactory outcome.

464. **Pickering, Donald E.** *(Dept. of Pediatrics, Univ. of Oregon Med. School, Portland, Ore.)*

The management of childhood nephrosis, by Donald E. Pickering and George R. Kerr. *G.P.* Mar., 1961. 23: 3:111-117.

Another of *G.P.'s* series of articles on practical therapeutics, this article discusses the improved outlook for children with the nephrotic syndrome, clinical symptoms of the typical syndrome, the need for comprehensive clinical and laboratory evaluation in the initial assessment of the child, and major aims and general considerations in drug therapy and treatment. A program of management during the active phase of the condition and during the postdiuretic stage, when the child is hospitalized, and for long-term care, follow-up, and re-evaluation is outlined. Complications associated with long-term steroid therapy are discussed.

NUTRITION—GREAT BRITAIN

See 406.

OCCUPATIONAL THERAPY

465. **Troyer, Beverly L.** *(1810 S. Fifth St., Alhambra, Calif.)*

Sensorimotor integration; a basis for planning occupational therapy. *Am. J. Occupational Ther.* Mar.-Apr., 1961. 15:2:51-54.

Sensorimotor behavior develops through a definite sequence; the writer assesses the processes involved in sensation and motion and examines learning as it relates to the problem. In applying this knowledge therapeutically, the therapist needs to understand how normal skills are developed and to use this information in evaluating the disabled person's treatment needs. In rebuilding the patient's ability, each step in skill development must be included; results will be successful to the point that the disability is correctable. This paper is a summary of a master's thesis completed at the University of Southern California.

OLD AGE—ILLINOIS

466. **Breckinridge, Elizabeth L.** *(Illinois Public Aid Comm., 160 N. LaSalle St., Chicago, Ill.)*

Services for aging and rehabilitation in Illinois Public Aid Commission. *Ill. Med. J.* Feb., 1961. 119:2:82-85.

Discusses briefly the development of various services for the aging in Illinois by the Illinois Public Aid Commission and its Advisory Committee on Aging. (See *Rehab. Lit.*, Aug., 1957, #1006.) Results achieved in the Geriatrics Rehabilitation Program and the Rehabilitation Education Program since their initiation in 1956 and 1957 are reported. So much interest has been aroused in the education program that the Commission is compiling teaching materials to be published during 1961. (For a report on the Rehabilitation Education Service, see also *Rehab. Lit.*, May, 1959, #381.)

OLD AGE—PROGRAMS

See 402; 406; 407; 412.

PARALYSIS AGITANS—DIAGNOSIS

467. **Brumlik, Joel** *(Chicago Wesley Memorial Hosp., 250 E. Superior St., Chicago 12, Ill.)*

Quantitation of muscle tone in normals and in parkinsonism, by Joel Brumlik and Benjamin Boshes. *Arch. Neurol.* Apr., 1961. 4:4:399-406.

Muscle tone of 30 normal subjects and 30 patients with parkinsonism was evaluated by means of an electromechanical device; data are analyzed in terms of torque and the muscle complex primarily responsible for the observed torque. A similarity in variability between the four torque values was found in both normal subjects and those with parkinsonism. Variables, such as duration of illness and age of the patient, showed no significant degree of correlation with muscle tone in either group of persons tested. The advantages of electromechanical measurement of muscle tone in parkinsonism as an aid in the evaluation of therapeutic measures are discussed.

PARALYSIS AGITANS—MEDICAL TREATMENT

468. **Heller, Grant L.** *(Dept. of Neurology, Univ. of Michigan Med. School, Ann Arbor, Mich.)*

Tolbutamide in the treatment of parkinsonism, by Grant L. Heller, Russell N. DeJong, and Kenneth R. Magee. *J. Am. Med. Assn.* Apr. 15, 1961. 176:2:148-149.

A report of a double-blind study of 39 patients with

parkinsonism, given both tolbutamide and a placebo, either alone or in combination with other antispasmodic or antihistaminic drugs. Neither tolbutamide nor the placebo had an appreciable beneficial effect; there was no significant difference when the two were compared, both when used singly or in combination with drugs ordinarily used in the treatment of parkinsonism. Findings did not confirm the therapeutic value of tolbutamide as reported in a previous article of the March 26, 1960, *Journal* (see *Rehab. Lit.*, June, 1960, #446).

In the current issue, on p. 142, there appears an editorial titled "Second Thoughts," urging caution against too enthusiastic acceptance of the drug for use in diseases other than diabetes. Three communications, including a rebuttal from the author of the preliminary report of last year, appear in "Letters to the Journal," p. 166-167.

PARAPLEGIA—EQUIPMENT

469. Von Werssowetz, Odon F. *(Texas Rehab. Center, Gonzales, Tex.)*

Role of orthetics in rehabilitation of hands in quadriplegia of spinal origin. *Arch. Phys. Med. and Rehab.* Apr., 1961. 42:4:279-285.

In same issue: Use of nylon "muscle" in functional bracing in severe quadriplegia, by John S. Young (and others). p. 286-289.

Orthetic devices for the quadriplegic patient should attempt to restore the basic hand-arm movement pattern and should be selected on the basis of the degree of severity and distribution of involvement, as well as the degree of complicating deformities and contractures. A tubular adaptive device, designed at the Texas Rehabilitation Center, permits easy exchange of everyday utensils by the patient without assistance. Leaf-spring hinged clasps, in place of the usual buckles and straps used to secure hand splints in place, allow the patient to apply and remove the orthesis by himself. Problems in the assessment of involvement and residual muscle strength are discussed. Article is illustrated.

Dr. Young *(1599 Ingalls St., Denver 15, Colo.)* presented a case history illustrating the basic components of upper-extremity function and mechanical devices that can improve functional ability in the person with severely paralyzed upper extremities. Nylon "muscles" activated by carbon dioxide power the ball-bearing feeding mechanism described and illustrated.

See also 401; 424.

PHYSICAL EFFICIENCY

470. Hellebrandt, F. A. *(Motor Learning Research Laboratory, Univ. of Wisconsin Medical School, Madison, Wis.)*

The influence of athetoid cerebral palsy on the execution of sport skills: tennis and golf; a study of one case, by F. A. Hellebrandt and Joan C. Waterland. *Phys. Therapy Rev.* Apr., 1961. 41:4:257-262.

A report of another phase of the research studies being conducted by Dr. Hellebrandt and her coworkers at the University of Wisconsin Medical School and School of Education (see *Rehab. Lit.*, May, 1961, #378, for analysis of skills in bowling). Similar methods were used in the analysis of skill in performing a forehand drive in tennis and the drive in golf; the same patient participated in the bowling study. Conclusions were: the will to perform the activity is unimpaired and the act itself is conceived adequately; volitional component of the response is as effective as that of the average novice. No involuntary movements marred the execution of primary movement patterns.

471. Huddleston, O. Leonard *(1 Pico Blvd., Santa Monica, Calif.)*

Evaluation of physical disabilities by means of patient profile chart, by O. Leonard Huddleston (and others). *Arch. Phys. Med. and Rehab.* Apr., 1961. 42:4:250-257.

The patient profile chart described here was developed at the California Rehabilitation Center to record functional activity scores and muscle grades, useful for quick comparison and rapid evaluation. Its clinical application was studied in groups of patients with chronic poliomyelitis and traumatic quadriplegia. The chart is recommended as a research instrument conceivably capable of producing information useful in establishing minimal muscle profile lines for patients with different types of disability. Also standardized forms for predictable potentialities for patients with given disabilities might possibly be worked out on reference profile charts, with pertinent treatment goals.

472. Montero, Jose C. *(1680 Mission St., San Francisco 3, Calif.)*

Measuring the work capacity of the disabled. *Indust. Med. and Surg.* Apr., 1961. 30:4:138-140.

Physical and emotional demands of the job, working conditions, and job hazards must be taken into account in analyzing the suitability of placing the handicapped person in a specific job. In order to estimate how the handicapped person will perform on the job, the physician should consider, in the medical examination, the limitations imposed by the handicap and the physical and emotional capacities of the individual. Work assessment methods used at the May T. Morrison Rehabilitation Center of San Francisco are discussed.

473. Thomas, Charles W. *(Highland View Hosp., Harvard Rd., Cleveland, Ohio)*

An analysis of psychomotor responses of adult hemiplegic patients, by Charles W. Thomas (and others). *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:185-188.

A psychomotor test, the Thomasat, developed at Highland View Hospital (see also *Rehab. Lit.*, this issue, #495) was used in an investigation of the possibility of differential performance between right and left hemiplegics and a control group of patients without diagnosed organic brain pathology. The test is used to evaluate motor skills of the upper extremities in determining work levels of those with marginal vocational potential. Hand function, tactile perception, and eye-hand co-ordination are also tested. The comparative analysis of the groups' performance indicated, within the limits investigated, that the groups were relatively undifferentiated. Disabilities of patients in both groups included hemiplegia, paraplegia, quadriplegia, multiple sclerosis, amputations, spinal cord injuries, and various other neurologic and orthopedic disabilities. Findings of this study and previous ones made at Highland View Hospital support the contention that,

as a group, all hemiplegics are equally difficult to rehabilitate vocationally.

PHYSICAL EXAMINATIONS

474. Schenker, A. W. *(U.S. Army Dispensary, 90 Church St., New York 7, N.Y.)*

The accurate measurement of neuromuscular and musculoskeletal disabilities. *Military Med.* Mar., 1961. 126:3:207-213.

Describes, and illustrates the use of, a new fluid goniometer designed by the author for measuring range of motion. It also measures, to an accuracy of ±2 degrees, any musculoskeletal deformity. Dr. Schenker recommends a research project to establish new range of motion standards for accurate appraisal of neuromuscular and musculoskeletal disability.

PHYSICAL MEDICINE

475. Conant, Roger G. *(700 Main St., Hartford 15, Conn.)*

The use and abuse of physical therapy. *Indust. Med. and Surg.* Apr., 1961. 30:4:152-154.

In considering the cost of physical therapy to the industrial organization, the physician should guard against its injudicious use. Wisely prescribed, such treatment benefits the company in promoting productivity and allaying the employee's pain and anxieties. When unwisely prolonged, physical therapy can encourage malingering. The treatment of nonoccupationally incurred injuries poses problems requiring considerable judgment. Ways of controlling the use of physical medicine in the industrial medical department are reviewed briefly.

PHYSICAL THERAPY—PERSONNEL

476. Sabloff, Jack *(Pennsylvania Dept. of Health, Harrisburg, Pa.)*

Physical therapy in public health. *Phys. Therapy Rev.* Apr., 1961. 41:4:262-265.

Using crippled children's programs as an illustration, Dr. Sabloff points out the broadening responsibilities of the physical therapist in the public health field. The therapist is a member of a more complex treatment team than formerly; direct service is still, however, one of his most important functions. Today it is vital for the therapist in public health work to be aware of preventive aspects of case finding and care, to understand the work of other disciplines, and to serve as a consultant, particularly to public health nurses and medical social workers. He must give attention to the patient's family and their problems, to the community and its needs, and to the furthering of better physical therapy programs.

POLIOMYELITIS

477. Alexander, E. Russel *(Univ. of Washington School of Medicine, Seattle, Wash.)*

The extent of the poliomyelitis problem. *J. Am. Med. Assn.* Mar. 11, 1961. 175:10:837-840.

In same issue: Epidemiologic considerations, A. D. Langmuir. p. 840-843.—Standardization, licensing, and availability of live poliovirus vaccine, Roderick Murray. p. 843-846.

An analysis of the downward trend of annual poliomyelitis incidence rates following the peak period of 1950-1954. Although reversed upward in 1958 and 1959, the trend for 1960 is estimated as lower than for either of the two previous years. Geographic and epidemiologic patterns, use of vaccine and its effectiveness, and immunization surveys reveal that significant proportions of the public are inadequately protected. The disease continues to occur in a repetitive pattern, predominantly among preschool children of lower socioeconomic background, often in crowded urban centers, in all cases reflecting the distribution of the residual unimmunized population.

Dr. Langmuir *(1600 Clifton Rd., Atlanta, Ga.)* reviews experience with the Salk vaccine, the uses and limitations of the oral vaccine developed by Dr. Sabin and others, and the problems of epidemic control and possible eradication of the disease.

Dr. Murray *(Natl. Institutes of Health, Bethesda, Md.)* discusses problems in the production and use of safe and effective live poliovirus vaccine. Strain selection and manufacturing problems are discussed in some detail. Utilization problems are discussed in greater detail in Dr. Langmuir's article.

PROSTHETICS

See 401.

PSYCHOLOGICAL TESTS

478. Hirschenfang, Samuel *(848 E. 28th St., Brooklyn 10, N.Y.)*

Further studies on the Columbia Mental Maturity Scale (CMMS) and Revised Stanford Binet (L) in children with speech disorders. *J. Clinical Psych.* Apr., 1961. 17: 2:(171).

A report of an evaluation of the revised version of the Columbia Mental Maturity Scale in a hearing and speech clinic setting. In a comparison of scores from 45 Revised Stanford-Binet (L) and CMMS records of children from 3.41 to 14.58 years of age, correlation of results was high enough to warrant the assumption that both tests can be used in estimating intellectual functioning of children with speech disorders. However the CMMS appeared to penalize children below 3½ years of age as it tends to be more difficult for them to comprehend what is expected of them. Further revision of CMMS scoring is seen as necessary.

See also 495.

PSYCHOLOGY

479. Dyer, Gus W. *(VA Hospital, Chillicothe, Ohio)*

A commonsense version of existential therapy. *Am. Arch. Rehab. Ther.* Mar., 1961. 9:1:20-27.

An explanation of the concepts of existentialism and how they may be applied in therapeutic situations to aid the neuropsychiatric patient emerge from past and present habits and learn to experience a meaningful life. Only when the patient himself determines his long-range goals and works to achieve them can he be considered rehabilitated.

480. Lemkau, Paul V. *(615 N. Wolfe St., Baltimore 5, Md.)*

The influence of handicapping conditions on child

development. *Children.* Mar.-Apr., 1961. 8:2:43-47.

Lack of sensory stimulation and experience retard development in the handicapped child; new scientific findings concerned with the stimulus-response theory suggest that the first concern in preventing disordered personality development in handicapped children is maximal restoration of sensory input. The effects of over- and under-stimulation, the age at which disability develops, the disturbances caused by various types of handicaps, all suggest further areas of research if harmful effects are to be overcome.

481. Sandler, Anne-Marie *(St. George's Hospital, London, Eng.)*

Piaget's approach to problems of intellectual development, by Anne-Marie Sandler and Joseph Sandler. *Cerebral Palsy Bul.* 1961. 3:1:25-28.

A research psychoanalyst and a child therapist, a former assistant to Professor Piaget, discuss briefly his approach to the assessment of intellectual development in children. Differences in Piaget's system of thought and the usual psychometric approach are illustrated by two examples taken from the Terman-Merrill revision of the Stanford-Binet tests. Rather than being concerned with the allocation of abilities to various age levels, Piaget attempts to understand the development of internalized structures and mechanisms that aid the child in understanding and solving intellectual problems.

See also 410; 487.

PSYCHOLOGY—PERSONNEL

482. American Association on Mental Deficiency. Committee on Psychology *(Central Office, P.O. Box 96, Willimantic, Conn.)*

Training of psychologists in mental retardation. *Am. J. Mental Deficiency.* Mar., 1961. 65:5:634-651.

Highlights of the discussions, conclusions, and recommendations of a 2-day conference sponsored by the American Association on Mental Deficiency and the American Psychological Association, held in Washington, D.C., in November, 1958, are covered in the following articles:

(Introductory statement), AAMD Committee on Psychology.—Some issues of graduate education and training of psychologists in mental retardation,Eliot H. Rodnick.—Mental retardation; a social problem, Joseph H. Douglass.—Developments in psychological theory and knowledge relevant to mental retardation, James Gallagher.—Report of APA-AAMD Joint Committee on Training of Psychologists in Mental Retardation.

READING

483. Groelle, Marvin C. *(Oakland Public Schools, Oakland, Calif.)*

Some results and implications of reading survey tests given to educable mentally retarded children. *Exceptional Children.* Apr., 1961. 27:8:443-448.

Results of reading tests administered to educable mentally retarded pupils in Oakland, Calif., secondary schools in 1956 and 1959 were analyzed to determine learning trends, problems in teaching reading to such pupils, and the implications for planning reading programs. The rather unique successive screening technic used in the 1956 city-wide survey is described. The most noticeable trend in the reading pattern in both surveys was the tendency for an increasing discrepancy between over-all reading age and mental age as pupils became older and progressed through the program. Benefits to be expected from systematic city-wide reading surveys are discussed.

REHABILITATION—GREAT BRITAIN

484. Randle, A. P. H.

The legislative basis of rehabilitation. *Annals Phys. Med.* Feb., 1961. 6:1:28-33.

The historical foundation of social service in Great Britain is traced from medieval days down to the present time; following World War II a whole series of acts was passed, reorganizing social service on a national basis. Discussed in some detail are provisions of the National Health Service Act, the Disabled Persons (Employment) Act, and industrial rehabilitation units recommended by the Tomlinson Committee in 1943 and authorized under the 1944 Disabled Persons Act. Sheltered employment is provided by Remploy Ltd., a corporation set up under the Ministry of Labor by local authorities and voluntary organizations. The writer points out that ample powers for providing rehabilitation services have been authorized by the state; it is now the responsibility of local authorities to use the permissive power.

REHABILITATION—PROGRAMS

See 411.

REHABILITATION—RECORDS

See 471.

SCHOOL BUILDINGS

485. Graham, Ray *(Div. of Special Education, Illinois State Dept. of Public Instruction, Springfield, Ill.)*

Safety features in school housing for handicapped children. *Exceptional Children.* Mar., 1961. 27:7:361-364.

Second of a series of articles on safety features in schools for the handicapped, Dr. Graham's discussion emphasizes the need for careful training and planning to meet hazardous conditions that may arise. The handicapped need more than the usual amount of training in these respects and their safety is closely related to physical facilities of the building. General and specific considerations in the evaluation and planning of safety programs are outlined. It should be recognized that cheap construction and practices of cutting costs by using inferior materials may mean the difference between hazards and security. An adequate safety program is an essential part of the teaching-learning process.

SCOLIOSIS

486. Bennett, Robert L. *(Georgia Warm Springs Foundation, Warm Springs, Ga.)*

Recognition and care of early scoliosis. *Arch. Phys. Med. and Rehab.* Apr., 1961. 42:4:211-225.

A discussion of the paralytic and idiopathic forms of scoliosis, their pathogenesis, clinical findings used in identifying various types of spinal curvatures, and the

specific methods of treating each. Early recognition of persistent lateral and radial deviations of the spine and application of preventive and corrective principles in treatment are essential if stuctural deformity is to be kept at a minimum. Treatment of early scoliosis calls for regional mobilization of the spine, muscle re-education, support of the spine (through use of orthetic devices or surgical procedures to maintain or correct alignment), and limitation of activity. Dr. Bennett states that, in general, gymnastics have no place in the care of scoliosis.

SOCIAL WELFARE

See p. 172.

SPECIAL EDUCATION

487. Kaya, Esin *(74-40 46th Ave., Elmhurst, N.Y.)*

A curricular sequence based on psychological processes rather than subject content. *Exceptional Children.* Apr., 1961. 27:8:425-428, 435.

In attempting to formulate a curricular theory of the type proposed, Miss Kaya starts with the premise that learning experiences should be organized on the basis of psychological development, with subject content providing the setting within which learning takes place. A basic curricular sequence should be a continuous one without reference to grade levels, to meet individual differences in rates of learning. Piaget's theories in regard to the development of thinking are suggested as the bases of the sequence. Application of the theoretical plan to classroom situations, materials and methods based on the theory, and curriculum guides are suggested as possible research projects.

See also 403; 410; 481.

SPECIAL EDUCATION—ILLINOIS

488. Matson, Virginia F. *(Grove School, Libertyville, Ill.)*

Educational treatment center for disturbed, handicapped children; day school educates children regular schools cannot serve. *Chicago Schools J.* Apr., 1961. 42:7:317-324.

General and specific goals of an experimental day school for children with severe psychological and neurological disorders are discussed. Administration, staff qualifications, psychological testing methods, experimentation in curriculum and educational methods, and experience in teaching brain-damaged children are explained. Children in the program are making excellent progress where once it was believed they would eventually need lifetime institutional care.

SPECIAL EDUCATION—ADMINISTRATION

489. Lange, Drexel D. *(Iowa State Dept. of Public Instruction, Des Moines 19, Iowa)*

Interpretation of functions, by Drexel D. Lange and Geraldine A. Busse. *J. School Health.* Apr., 1961. 31:4: 129-132.

A report of the work of a joint committee of the Iowa State Department of Public Instruction's Division of Special Education and the State Department of Health's Division of Public Health Nursing, which is studying and attempting to define roles and relationships of the school nurse and special education worker in the planning, development, and administration of programs for children with school adjustment problems. Need for a vocabulary understood by personnel in both professions was demonstrated.

SPECIAL EDUCATION—EQUIPMENT

490. Dorward, Barbara

Teaching aids and toys for handicapped children. Washington, D.C., Council for Exceptional Children, 1960. (64) p. illus.

The toys and teaching aids described were originally developed to meet the needs of cerebral palsied children in nursery school or kindergarten and have been used with brain-injured, mentally retarded, and multiply handicapped children. Materials to teach size and shape perception have been found useful in instructing the visually handicapped. Purpose of each device or toy, methods for its use, and construction details are included, with illustrations and suggestions for possible modifications. Teachers and parents should find the booklet most instructive; the devices and toys are easily and inexpensively constructed, interesting to children as recreational activities, and an aid in teaching hand co-ordination, depth perception, color matching, and reading and number readiness.

Available from Council for Exceptional Children, 1201 16th St., N.W., Washington 6, D.C., at $1.50 a copy.

491. Falconer, George A. *(Illinois State Normal Univ., Normal, Ill.)*

A mechanical device for teaching sight vocabulary to young deaf children. *Am. Annals of the Deaf.* Mar., 1961. 106:2:251-257.

A description of the development and testing of an experimental teaching machine to determine its effectiveness as a teaching device. The device, using multiple-choice items as instructional material, proved useful in supplementing work in the classroom. The article is adapted from a doctoral dissertation completed under the direction of Dr. Samuel A. Kirk at the University of Illinois. A less technical description of the machine and results obtained was written by the author for *Volta Review,* February, 1960 (see *Rehab. Lit.,* Apr., 1960, #305).

SPEECH CORRECTION

492. Holinger, Paul H. *(700 N. Michigan Blvd., Chicago 11, Ill.)*

Vocal cord paralysis in infants, by Paul H. Holinger, Kenneth C. Johnston, and Andreas C. Kodros. *Eye, Ear, Nose and Throat Month.* Feb., 1961. 40:2:109-113.

Experience with 63 infants under 18 months of age, seen over a 13-year period, is reviewed. Of the group, 42 had bilateral paralysis, 8 unilateral right vocal cord paralysis, and 13 unilateral left. Diagnosis of laryngeal paralysis in infants requires direct examination of the larynx; administration of oxygen is often necessary throughout the examination. Indications for such examination are discussed, as well as clinical findings. In this series of patients, the lesion in bilateral vocal cord paralysis was most frequently a part of a generalized

central nervous system disorder, with prognosis regarded as relatively poor.

See also 478.

SPEECH CORRECTION—PERSONNEL

493. Johnson, Kenneth O. *(1001 Connecticut Ave., Washington 6, D.C.)*

Trends in the profession, by Kenneth O. Johnson and Parley W. Newman. *Asha.* Apr., 1961. 3:4:109-114.

Information from 193 colleges and universities claiming to provide professional preparation in speech pathology and audiology is analyzed in the light of the number of degrees granted between 1953 and 1959 and estimates for 1960-61. Data are also given on enrollments, levels of clinical certification for which graduates could qualify, practicum experience available during training, qualifications and size of faculty staffs, and institutions offering opportunity for training leading to advanced certification. The study was conducted in 1960 by the American Speech and Hearing Association in co-operation with the U.S. Office of Vocational Rehabilitation, Office of Education, and Children's Bureau.

494. Rosen, Jack *(165 Elk Pl., New Orleans 12, La.)*

The community speech and hearing center as a representative of the profession. *Asha.* Apr., 1961. 3:4: 117-119.

An effective community speech and hearing center committed to providing the clinical speech and hearing services needed by the community can enhance the status of the speech and hearing profession. Although services are administered in such settings as the hospital, rehabilitation center, health department, university clinic, and public school systems, the community center offers the qualified clinician opportunity to operate independently under policies, standards, and ethical practices established by the profession. Responsibilities and functions of such a center are discussed; diagnostic and therapeutic services are inseparable functions. Secondary functions must be selected on the basis of pertinency, community needs, and availability of staff and facilities.

VOCATIONAL GUIDANCE

495. Spangler, Donald *(Highland View Hosp., Harvard Rd., Cleveland, Ohio)*

The application of psychometrics in the vocational evaluation of the adult severely disabled, by Donald Spangler, Charles W. Thomas, and Mieczyslaw Peszczynski. *Arch. Phys. Med. and Rehab.* Mar., 1961. 42:3:180-184.

Criticisms, applications, and trends in the use of psychometrics in vocational evaluation of severely disabled adult patients are discussed in an attempt to establish a sound methodologic framework for the use of such tests in the rehabilitation process. The Thomasat test, developed at Highland View Hospital and found useful in screening disabled patients for work at various levels in a sheltered workshop, is described. Tests used in evaluating intellectual status, personality characteristics, and performance are considered as they are applied to such clients. Implications for research and two experimental situations in which psychometrics figured prominently are noted. Some progress has been made in the modification of testing instruments suitable for use with disabled adults.

See also 472.

VOCATIONAL GUIDANCE—PERSONNEL

496. Muthard, John E. *(Coll. of Education, State University of Iowa, Iowa City, Iowa)*

Barriers to effective rehabilitation: counselor opinion, by John E. Muthard and Marceline E. Jaques. *Personnel and Guidance J.* May, 1961. 39:9:710-716.

A statistical analysis of rehabilitation counselors' statements describing factors they regard as standing in the way of doing the best kind of rehabilitation job with clients. Opinions of 336 counselors from both state-federal and other agencies were considered by counselor type, level of experience, and training. Findings show that counselors think their agencies' policies, procedures, and practices conflict with counselors' ability to do more for clients and suggest a need for improved communication between counselor and agency leadership. Data also suggest some concern about lack of community resources and counselors' own competencies. Supervisors' competencies and clients' deficiencies are seldom reported as barriers to effective rehabilitation. This article is part of a larger study reported in a recent monograph by Dr. Jaques (see *Rehab. Lit.*, Mar., 1960, #141).

WALKING

See 422.

WORKMEN'S COMPENSATION

497. Jacobs, Carl N. *(Hardware Mutual Casualty Co., Stevens Point, Wis.)*

The present status and the future of workmen's compensation laws; the viewpoint of management. *Indust. Med. and Surg.* Mar., 1961. 30:3:119-123.

Critics of state administration of workmen's compensation propose the establishment of a federal system. Mr. Jacobs, as president of a company that provides coverage for a substantial number of workmen's compensation risks, points out accomplishments of the system under state laws in a program, for the most part, less than 10 years old. All parties involved, management and labor included, should review the needs and work for improvement in laws. The extension and co-ordination of rehabilitation services in workmen's compensation cases, the broadening of safety programs in industry, more equitable compensation, and the setting up of legal safeguards against radiation hazards in industry are challenges of the future.

Director of World Commission on Vocational Rehabilitation Named

JOHN A. NESBITT has been appointed to the new position of director of the World Commission on Vocational Rehabilitation of the International Society for Rehabilitation of the Disabled *(701 First Ave., New York 17, N.Y.)*. The Commission's objectives will be to overcome vocational problems confronting the disabled, increase employment of the handicapped, and identify problems in vocational rehabilitation for study and research. Mr. Ian Campbell, national co-ordinator of civilian rehabilitation in Canada, has been designated chairman of the Commission. Mr. Nesbitt received his M.A. degree in rehabilitation at Columbia University this May. He has been associated with the Institute of Physical Medicine and Rehabilitation, New York University Medical Center, in the therapeutic recreation department.

California Health Study Makes Recommendations on Rehabilitation

THE DECEMBER 1960 Report of the (California) Governor's Committee on Medical Aid and Health made the following recommendations on rehabilitation, that:

1. State subvention be offered to county and city agencies for rehabilitation services to the needy disabled and aged.
2. Rehabilitation principles be included in educational programs of the health professions by professional schools and societies, hospitals, nursing home associations, health departments, and voluntary agencies.
3. Training centers for rehabilitation specialists be expanded and recruitment intensified; that state and junior colleges, cooperating with rehabilitation services, develop new programs to train physical and occupational therapists.
4. The State Department of Public Health, in allocating federal and state matching funds, approve only grants for construction of integrated facilities.
5. Hospital rehabilitation facilities, staffed by teams of specialists, be operated as separate hospital units, and that charges for rehabilitation treatment be limited to the actual costs of only those particular services.
6. The state establish a program for evaluation and rehabilitation of severely disabled adults, the state to finance the costs of diagnosis and those treatment costs over and above the individual patient's ability to pay.
7. Agencies licensing institutions for the aged promote rehabilitation therein and provide training for their staffs, and that state funds should be available for this purpose.
8. Public assistance applicants and recipients be screened for disability and rehabilitation initiated when indicated, and that welfare agencies paying for nursing home care offer financial incentives to encourage nursing home operators to provide rehabilitation.
9. The state employ qualified disabled and promote their employment in industry by underwriting insurance for subsequent injuries attributable to or aggravated by the disability.
10. An interdepartmental co-ordinating council for state programs in rehabilitation be established to sponsor research, demonstration projects, evaluation studies, and educational programs in rehabilitation. The council should include the state directors of education, employment, mental hygiene, public health, and social welfare, or their representatives, and be assisted by a permanent staff of specialists in medical, social, psychological, and vocational aspects of rehabilitation, housed in the state department of public health.
11. Workmen's compensation laws be amended to cover rehabilitation costs, and that cash awards for permanent disability not be adversely affected by a patient's acceptance of restorative services.

Mississippi Southern College Offers Fellowship Grant in Hospital Recreation Service

APPLICATIONS from persons interested in hospital recreational services are being accepted at Mississippi Southern College, where the $2,000 Forest Park Foundation Fellowship is available. A scholarship is to be awarded to a person seeking a master of science degree in this area of interest. Details can be had by writing Dr. Jay S. Shivers, professor and head of recreation, Station A, Box 235, Mississippi Southern College, Hattiesburg, Miss.

Gallaudet Personnel Demonstrate Underwater Communication to Navy

A PICTURE STORY in which a faculty member and a student of Gallaudet College demonstrate to Navy underwater swimmers how to use the language of signs for underwater communication appeared in *This Week Magazine* on Sunday, May 28.

Sign language for underwater communications is now being used in limited form by the U.S. Navy to train both underwater demolition swimmers (frogmen) and divers. The system was initiated by and developed under the direction of Dr. Peter R. Wisher, chairman of the department of physical education and athletics at Gallaudet College.

Change of Address

J. A. PRESTON CORPORATION (equipment for physical medicine and rehabilitation). To: 71 Fifth Ave., New York 3, N.Y.

KAPAPS (HELLENIC REHABILITATION CENTER FOR DISABLED). To: 77, Alex. Ragavi St., Athens, Greece. Mr. Spiros S. Theologos, Director General.

A Comment on

Hospital Work Program for Mentally Limited Teen-Agers

"AN UNUSUAL EXPERIMENT has successfully placed mentally limited teen-agers in a general hospital setting. This program was worked out in cooperation with the Delaware Association for Mentally Retarded Children, which selected 'educable' candidates. The plan had the full support of the hospital's director of nursing. These 'limited' teen-agers were assigned such tasks as folding towels and caring for other supplies in the central sterile supply department, sorting pillow cases for the ironing machine, separating baby linens, etc. The reciprocal rewards of this experiment are worthy of note. The hospital was served. Simultaneously, as a community agency, the hospital was able to provide a gratifying education and work situation for a community group with restricted opportunity." —*From "Auxiliaries and Volunteer Service," by Mrs. Anne Gross, p. 56, 59-61, in* Hospitals, *April 16, 1961.*

Professional Salaries in Field Of Blindness To Be Surveyed

THE AMERICAN Foundation for the Blind has contracted for a survey to be carried out by the U.S. Bureau of Labor Statistics, to determine up-to-date information on salaries for 20 of the 69 job titles covered in the comprehensive *National Survey of Personnel Standards and Personnel Practices in Services for the Blind 1955*. The titles cover positions in the fields of education, administration, social work, and others (home teachers, vocational counselors, and mobility orienters). Salary trends since 1955 will be given and salaries in the field of blindness will be compared with those of professional personnel in other fields of health, education, and welfare.

The Foundation's publication *New Outlook for the Blind* will feature a series of articles highlighting the findings of the survey in its regular column "Job Talk."

Former PVA President Frost Dies

S. ROBERT FROST, aged 41, of Briarcliff Manor, N.Y., died suddenly on April 13. Twice president of the Paralyzed Veterans of America, he also had headed the Eastern PVA. For several years he has been president of Bright Star Industries, which manufactures electrical and electronic equipment and has a large plant in Clifton, N.J. Mr. Frost enlisted in the U.S. Army Air Force while a student at St. John's University. In 1942 he suffered a broken neck while training in Georgia and became a paraplegic.

A new edition of the handbook by Mr. Frost and his wife Alma, *Handbook for Paraplegics and Quadriplegics*, will be ready for distribution next September by the National Paraplegia Foundation, 432 Park Ave., S., New York 16, N.Y.

Sheltered Workshop Association Opens National Office

THE FIRST permanent national office of the National Association of Sheltered Workshops and Homebound Programs was established in Washington, D.C., on April 3. Antonio C. Suazo has assumed the position of executive director. Mr. Suazo was formerly with the Sheltered Workshops for the Disabled in Binghamton, N.Y. He will devote half his time to NASWHP affairs and spend the remainder as a field consultant for the National Rehabilitation Association *(1025 Vermont Ave., Washington 5, D.C.)*, offices of which are adjacent to the NASWHP headquarters.

Mr. William A. Hays is director of the NRA-NASWHP National Institute on Workshop Standards, which will soon begin a questionnaire survey of 650 sheltered workshops throughout the country as part of its project.

Meek To Be Executive Director Of National Health Council

PETER G. MEEK, on August 1, will assume the post of executive director of the National Health Council, 1790 Broadway, New York 19, N.Y. A specialist in health and welfare administration, Mr. Meek has been director of the New York office and northeast regional representative of the National Society for Crippled Children and Adults since 1956. He was the assistant director of the Commission on Chronic Illness from 1949 to 1956.

Dr. Myklebust Comments on Psychoneurological Learning Disorders in Children

"TERMS SUCH AS 'brain-damaged' and 'brain-injured' have been used to designate certain children presenting problems of behavior and development. These terms have marked limitations both clinically and scientifically. The disorder might be due to endogenous, biochemical, or maldevelopment factors rather than damage or injury per se. The term *psychoneurological* can be used for all behavioral deviations which have a neurological basis, irrespective of age of onset and specific etiology.

"The most common psychoneurological learning disorders seen in preschool children are *congenital apraxia,* and *congenital agnosia.* Expressive aphasia is a type of congenital apraxia; receptive aphasia is an example of congenital agnosia. In school-age children the most commonly encountered learning disorders are dyslexia, dysgraphia, and dyscalculia. Associated with these psychoneurological problems are an inability to learn the meaning of directions (east, west, etc.), confusion of left and right, and an inability to learn to tell time normally.

"From our work with children having such learning disorders, we have come to the following tentative conclusions.

1. The number of children having psychoneurological learning disorders, who otherwise have normal intelligence, is about five per cent of the school population.
2. These disorders are at least five times more common in males than in females.
3. Electroencephalography and neurological study indicate that most of these children have disturbances in occipital-parietal or the temporal-parietal areas.
4. When psychoeducational therapy procedures and medical treatment are inaugurated according to the specific type of psychoneurological problem present, the prognosis is favorable for these children."—*From "Symposium: Some Unsolved Problems in Pediatrics: Those Related to Speech and Learning—Psychoneurological Learning Disorders in Children," by Helmer R. Myklebust, Ed.D., p. 225-226, in the March 15, 1961, issue of* The Proceedings of the Institute of Medicine of Chicago.

AMA Reports on Rehabilitation Committees of Member Societies

RESPONDING TO A questionnaire sent out by the Committee on Rehabilitation of the American Medical Association, 41 of the Association's 54 constituent societies stated they have committees dealing with rehabilitation. Rehabilitation services have been surveyed by 13 constituent societies and 13 component societies. Six constituent societies have directories of rehabilitation services. A report listing the constituent societies having committees dealing with rehabilitation, names and addresses of chairmen, and availability of directories of rehabilitation services may be obtained from Dr. Ralph E. De Forest, Secretary of the Committee on Rehabilitation, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

Cerebral Palsy Bulletin Becomes Bimonthly Issues Monographs

STARTED IN 1958 by the Medical Advisory Committee of the National Spastics Society (England), *Cerebral Palsy Bulletin* has since grown in size (from 30 to 60-100 pages) and in scope. The field of interest it presently covers includes developmental medicine, child neurology and neurophysiology, and the problems of cerebral palsy and similar conditions.

The number of issues is being increased in 1961 from four times a year to six. The journal this year is also publishing four *Little Club Clinics in Developmental Medicine,* to be selected from:

Introduction to Developmental Assessment in the First Year, by Prof. R. S. Illingworth.

Lessons for the Paediatrician from the Study of Animal Behaviour, edited by S. A. Barnett.

Landmarks in the Study of Cerebral Palsy, by Prof. Paul E. Polani.

Cytogenetics and Chromosomes; A Guide for the Clinician, edited by John Hamerton.

Little Club Manual of Neurological Tests on the New Born Infant; A Report from the Little Club's Groningen Meeting, July, 1960, edited by Martin Bax.

This series of monographs takes its name from William Little, who first described cerebral palsy.

The subscription rate for both the *Cerebral Palsy Bulletin* and the *Little Club Clinics* is £2 (or $6) a year; for the *Bulletin* alone or the *Clinics* alone it is £1 ($3) a year. Separate copies of the *Bulletin,* including back issues, will be sold when available for 5s ($1) and copies of the *Clinics* for 10s ($2) post free. Volumes 1 (8 issues) and 2 are presently available at £10 and £4 respectively. The National Spastics Society is located at 28 Fitzroy Sq., London, W.1, England.

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